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The Journal of The SOUTH CAROLINA Medical Association

INDEX MEDICUS

A Lump in the Breast

Photodynamic Dermatoses

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LUME 58 JULY 1962 NUMBER 7

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a look at the literature



"Treatment results were good, and in many cases a dramatic response was noted. Many of the cases had previously failed to respond to various types of therapy, including, in some instances, other topical corticosteroid preparations."

—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84*:18, 1961

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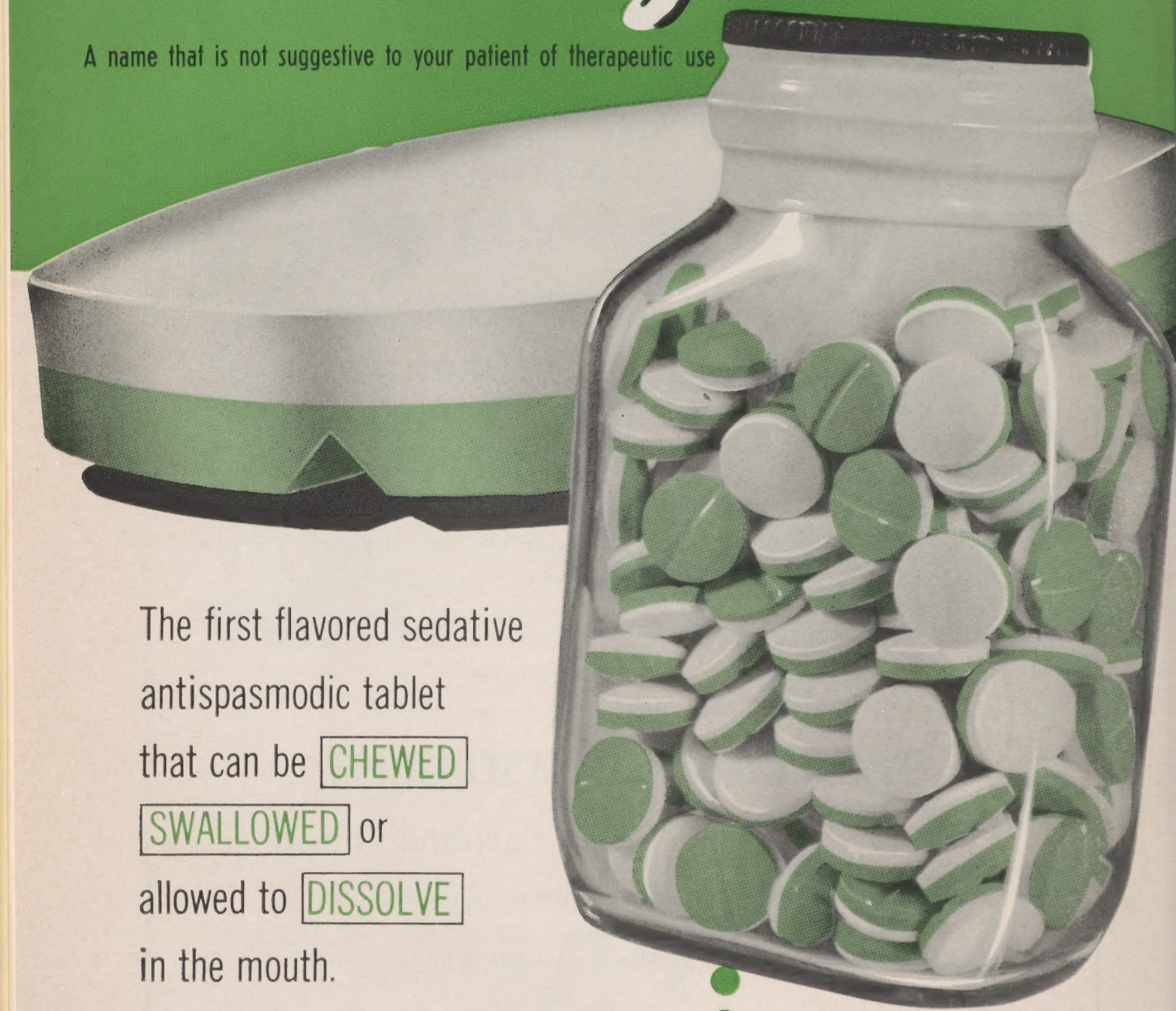
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2. Spoor, H. J.: N.Y. State J.M. 58:3292, 1958.
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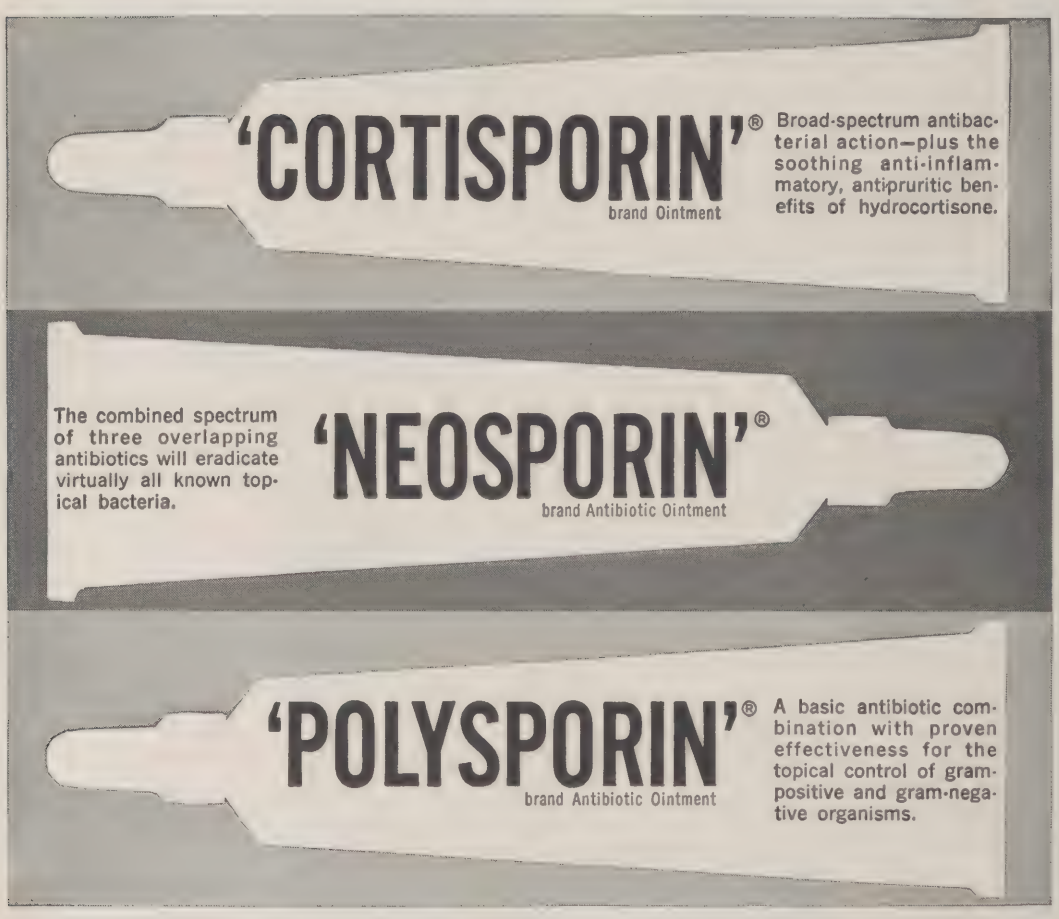
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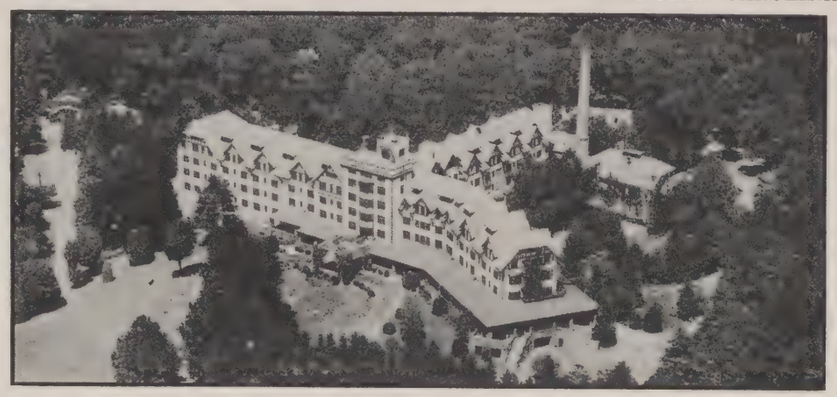
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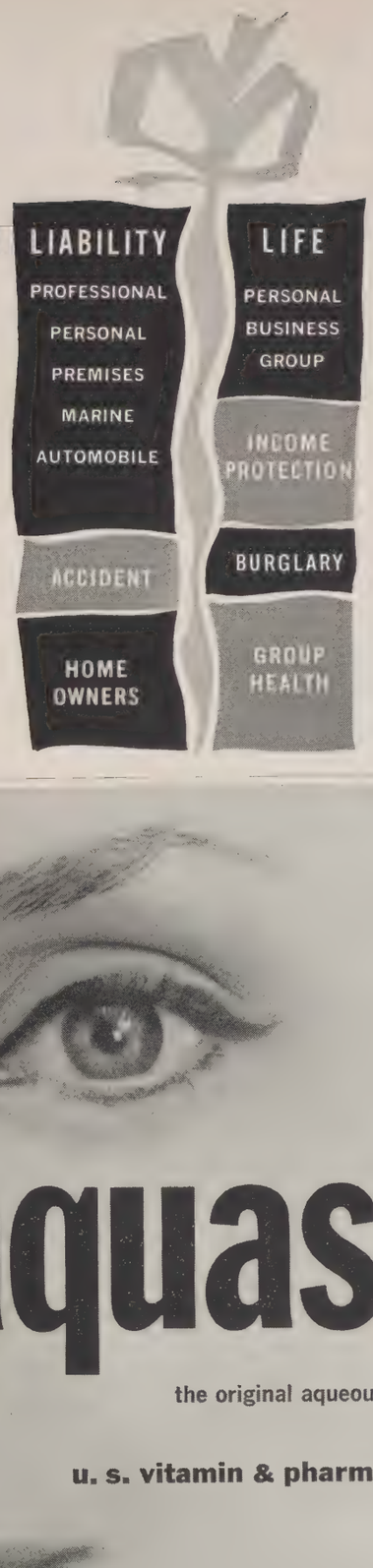
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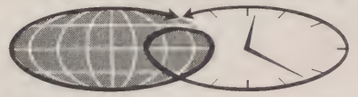
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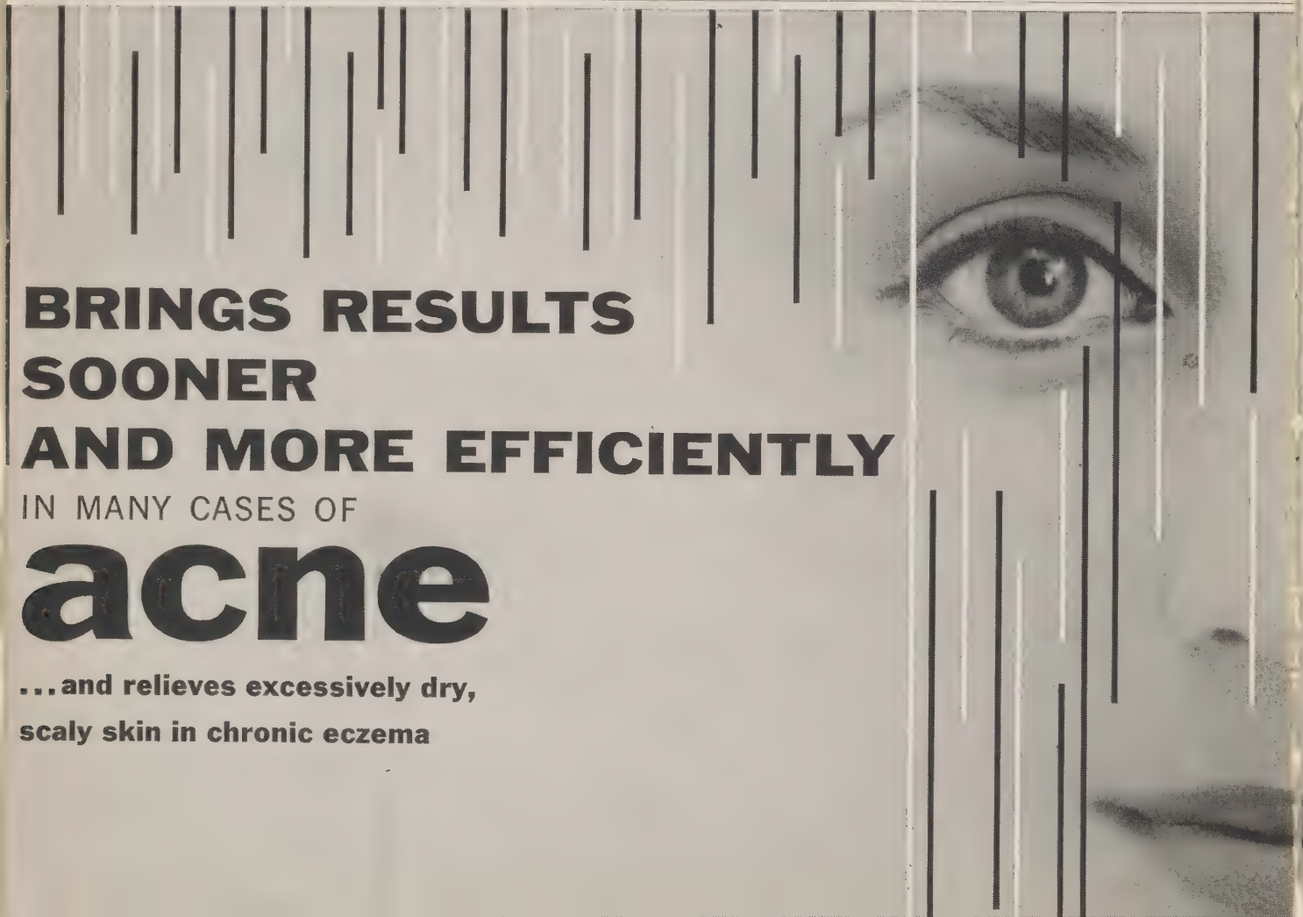
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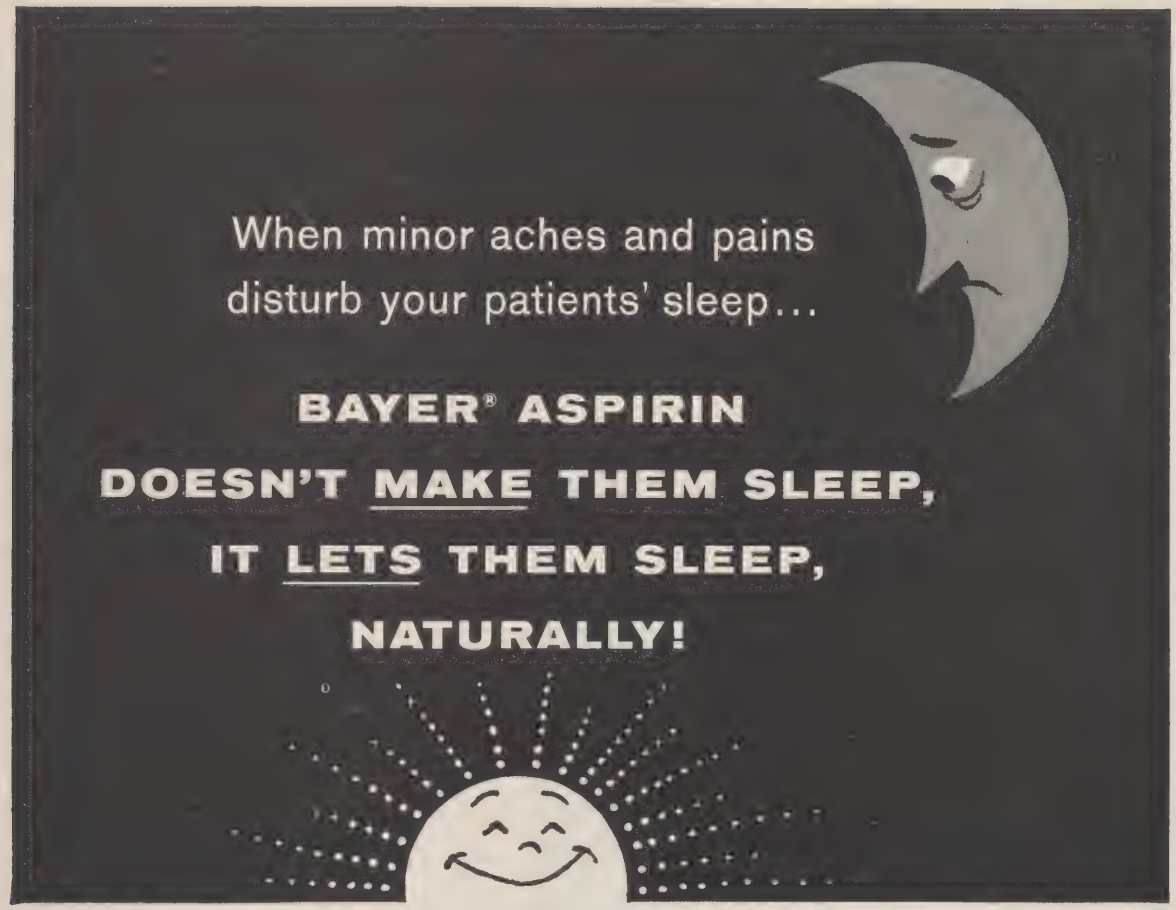
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VOLUME 58 July, 1962 NUMBER 7



THE LUMP IN THE BREAST

A TRANSCRIPTION OF A TELEVISION PRESENTATION

Jerome Urban, M. D.
John Hawk, M. D.
Harold Pettit, M. D.
Forde McIver, M. D.
Dale Groom, M. D., Moderator

The Medical College of South Carolina in cooperation with the South Carolina Education Television Center presents a medical symposium on The Lump in the Breast.

Dr. Groom: Good evening and welcome to another medical symposium over South Carolina's closed circuit television network. According to the American Cancer Society, this year from 55 to 60 thousand women will have a diagnosis made for the first time of carcinoma of the breast. Some four per cent of women who live to the age of 65 will develop this lesion. It is, of course, the most prevalent malignancy in the female. This illustrates both the importance of the problem medically and the challenge for future research. To discuss this problem we have a guest speaker from New York City, Dr. Jerome Urban from the famed Sloan-Kettering Memorial Center and the faculty of Cornell Medical School; from our own faculty Dr. Harold Pettit of the Department of Radiology, Dr. Forde McIver from the Department of Path-

ology, and Dr. John Hawk, Director of the Cancer Clinic.

Unlike carcinoma of the cervix, we have in this lesion no help in the early diagnosis comparable to the Papanicolaou smears. So any diagnosis of malignancy in the breast depends a great deal upon the examination, first by the patient and second by the physician whom she consults. Dr. Hawk, what procedure do you go through when a patient comes to you with a lump in the breast?

Dr. Hawk: Well, very fortunately, we have the opportunity tonight not only to tell you about the examination but also to show you how we examine the breast. This lady has been kind enough to come today to participate in this program so that we can demonstrate the examination of the lump in the breast. (To patient:) As I understand it, you asked to see a physician because you have felt a lump in your breast. When did you first find it?

Patient: Well, it was about three weeks ago.

Dr. Hawk: How did you happen to find this lump?

Patient: I was taking a shower and washing my left breast I found a lump.

Dr. Hawk: Has it changed any?

Patient: Yes, it's gotten smaller.

Dr. Hawk: Well, that's fortunate. When did it get a little bit smaller?

Patient: Right after my period.

Dr. Hawk: And when was that?

Patient: It started on Christmas Day.

Dr. Hawk: Was that a normal period? Did it come at the right time?

Patient: No, actually it was three or four days late which was rather unusual.

Dr. Hawk: Your periods are quite regular most of the time. Is that correct?

Patient: Yes, 28 or 29 days.

Dr. Hawk: At this point I would ask her about her medical history, about her past history and of course go into more detail as regards the finding of this lump in the breast. However, I think we should take just a moment to talk a little more in general about the necessity for finding the lump in the breast as early as possible, so that we can set the stage for the diagnosis of the lump, the finding



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of it by both the patient and the physician. This slide illustrates that the breast cancer may spread through either one of two groups of regional lymphatics, the axillary or the internal mammary. We try to find a lump in the breast before it has spread to either one of these; and certainly before it has spread beyond either of these groups to distant sites, making it incurable at that late stage.

The second slide shows why it is so important to diagnose the disease early. We can see that when the axilla is free of metastasis a cure rate of 83% can be achieved. If level one, the lowest or outer level of the axilla is involved by cancer, the cure rate drops to 65%; with level two, positive nodes, 45%; with level three, 28% and with an overall salvage of about 54%. We should remember also that there are certain benign lesions and certain developmental anomalies which we must differentiate from cancer. First of all, the prepubertal child may develop a lump beneath the areola which appears first on one side and appears to be a lump instead of the normal cyst development. This may occur as early as eight years of age; we've seen one at that age and some have been reported down to six and seven. This, of course, gives the mother a great deal of concern. She comes to you and wants to know what should be done about it. The important thing is not to take the lump out, because this is all of the breast tissue. If you remove the lump, you have removed the breast and there is no further development in the breast.

The third slide demonstrates some of the anomalies of the breast. These include poly-

mastia and polythelia, that is, multiple breasts and multiple nipples.

The fourth slide also demonstrates a virginal hypertrophy involving one breast primarily so that it outstrips its fellow. We should also remember that trauma may produce fat necrosis which will produce a lump that is very similar to the lump of carcinoma. Also we can have acute inflammatory changes and chronic inflammation, such as tuberculosis, which is now rare fortunately, and from syphillis and from various other chronic diseases. We see very few of these at the present time. With pregnancy and lactation a few inflammations may be present and certainly must be differentiated from neoplasm.

With this introduction I would like to proceed with the examination of the breast and show you just how we do go about it. Now, first of all we have the patient in an erect position and I examine her in this manner. First, with her arms at her side, looking for any asymmetry in the breasts, and we see here that the breasts are perfectly symmetrical and normal in appearance. Now will you put your arms above your head, please, and we will see again that they are perfectly symmetrical. Now with your hands on your hips, put your shoulders back and again there is no evidence of any retraction and no evidence of any asymmetry.

Now, as seen in the next slide, we occasionally have a patient who has a visible retraction that is apparent only when the patient raises the arm above the head. On the right side of this picture we see that with arms down, there is no retraction of the skin. With the arms elevated there is a great deal of retraction and the diagnosis of carcinoma is quite obvious. To go back to the examination in question, and recalculate the supposition of spaces to be sure there are no lymph nodes in these areas; we begin our cursory examination of the breast proper because most of the palpation of the breast is carried out while the patient is supine. However the palpation of the axilla is most effective and important with the patient at rest. Here I hold the left hand in my left hand and I palpate in the axilla. I palpate and find no evidence of any nodes or any enlargements in this area. I also palpate posteriorly and superiorly to cover the entire axilla. The same procedure, of course, is completed on the opposite side and again there are no positive findings in this patient. Now with the patient supine, we begin the palpation of the breast proper. Particularly if the patient has a pendulous breast, it will be important to place a pillow beneath the shoulders so as to flatten the breast against the chest wall. Then it is possible to palpate systematically all fibers of the breast, being sure not to miss any areas and also to search for any nipple discharge by stripping the various quadrants of the breast to the nipple and areola, as you see here in this manner; and if any nipple discharge should be found, I would then take a slide, touch it to the breast, take the slide and make two smears which I would then air-dry and send to the Pathology Department.

Dr. McIver, what would you do in the Pathology Department with these breast smears?

Dr. McIver: Receiving these smears, we would give them a routine stain. It should be pointed out that most patients with breast discharge do not have cancer. As a matter of fact, most patients with a bloody discharge do not have cancer. On the other hand, of those patients who have a bloody discharge, there would be a greater percentage of cancer in that group than in the group with the serous discharge. Now, this is an example of cancer cells. You see a large dark nucleus, a rather scanty cytoplasm, a rather bizarre picture of malignant cells. The next slide shows another picture. In this case the cells are much more uniform, they are smaller and this actually produces a papillary structure indicative of either adult papilloma or papillomatosis. It is important to realize, of course, that a negative smear is not of useful significance.

Dr. Hawk: We would then examine the opposite side, taking care to palpate again the entire breast and all quadrants and we would also demonstrate to the patient that we pal-

pate with the flat of our fingers and not with the tips because you feel a little too much with the tips. You feel irregularities which really aren't there. In the elderly patient we frequently find a so-called empty space behind the areola so there are ridges of tissue about the areola where the breast tissue begins. These ridges are not abnormal. These ridges are normal in the atrophic breast. We frequently will find a movable discreet nodule which may appear on transillumination to pass light with ease. I might say a word about transillumination, that this is a technique that is useful at times, but is somewhat time consuming in that it is necessary for one to become adapted to the dark before trying to transilluminate a nodule in the breast. Likewise, dark and cloudy fluid may not transilluminate well and consequently may be confused with a solid mass. Now if the nodule has perfectly cystic characteristics, if I am pretty sure that it is a cyst, I have no hesitancy about aspirating it with a small needle which is inserted directly into the nodule one time, aspirating with the syringe, fluid is removed, it is put in with an equal amount of formalin and is sent to our Pathology Department for examination.

Dr. Groom — Dr. McIver, what do you do with this fluid?

Dr. McIver: A specimen of this sort is treated by spinning down the cells, making of the cell clot a routine paraffin section and stain. As you can see, in this slide we have found a group of so-called apocrine type cells. These cells are highly characteristic of cystic mastitis or mastiplasia as we call it, and are in fact quite diagnostic. On the other hand it should be pointed out that the presence of this type cell and the presence of mastiplasia do not rule out cancer. Therefore, it is important at this time that the report be given back to the surgeon and the surgeon must judge with that report and the clinical data available what is to come next.

Dr. Hawk: When I find a cyst in the breast and aspirate it, if the cyst disappears completely, I simply have the patient come back after her next monthly period and check her



DR. McIVER

again. If the cyst has disappeared, then no further treatment is necessary except periodic follow-ups. On the other hand, if the cyst reappears, and if after aspiration, there is still nodularity present, then a surgical investigation, that is excision, should be carried out for further diagnosis to be sure that this is not a neoplastic process. Now likewise in palpating the breast, I might find a solid mass characteristic of a fibroadenoma. This I would not aspirate, but if I found a solid mass which I thought suspicious of carcinoma, there are certain instances in which aspiration biopsy would be carried out. Primarily we use aspiration biopsy in the elderly patient in whom we wish to save anesthesia and operative time and the time of definitive surgery. We also use it in the more advanced lesion with skin fixation, in the inflammatory carcinoma where the treatment will primarily be by radiation therapy and in some other instances. We have a technique of aspiration biopsy with which we've been quite satisfied. Our specimen is sent on an Onco sponge to the Pathology Department.

Dr. McIver, what do you do with an aspiration biopsy specimen?

Dr. McIver: An aspiration biopsy, when it arrives on an Onco sponge and in formalin, is sectioned in the routine manner. A paraffin section is made and is stained in the usual hematoxylin and eosin technique. This is exactly the same as any other biopsy, except of course, in the average case, the amount of tissue available is less. When two points are kept in mind, we believe that an aspiration

biopsy can be quite useful. These two points are first, that the pathologist must restrain himself from attempting to do more than the amount of tissue available permits. Secondly, the physician must be prepared to regard a negative report as of virtually no significance. It is not likely that difficulty will be encountered if one is conservative in using this diagnostic tool. In this slide for example it is absolutely clearcut, with these large bizarre cells, that carcinoma is present in this tissue. We have no more hesitation in reporting a slide of this quality than we would a routine section.

Dr. Hawk: Now if we have a very small nodule, which is what we hope to find, we feel that aspiration biopsy is not the best method for getting a diagnosis. We prefer to prepare the patient for definitive surgery and to carry out a local incisional or excisional biopsy in the operating room.

What can be achieved with such a local excision? How many of our local excisions will turn out to be neoplastic in general? The next slide will show the figures for us.

In this slide from the Memorial Hospital experience in 1,434 local excisions for clinically benign lesions, 1,280 benign lesions were found in operation but there were 154 cancers, or approximately 10 per cent. In this 10 per cent of cases then a lesion that was not suspected of being cancer turned out to be neoplastic. Now, let us assume that in the operating room we have removed or have taken a section of a lesion and have given it to the pathologist. What do you do with these specimen that we give you?

Dr. McIver: At the present time I believe that we have an opportunity to produce a very satisfactory specimen at the time of frozen section by utilizing the frozen blade technique to obtain sections and do a rapid stain. This entire process should not take more than three to five minutes from the time the specimen is received. When this is done, one can get a frozen section of the quality demonstrated in this picture. 1. This compares favorably, I think, with the following slide which demonstrates the same patient and the same lesion on permanent section. 2. The diagnosis of malignant disease, of course, is very much more important but malignant cells are quite obvious with the proper frozen section technique and this slide shows a permanent section. 3. The following slide shows the frozen section on the same case. 4. The first slide in the last two groups was a permanent section. This present slide is a frozen section and I think you can see the cellular detail. Now of course, as we know, surgeons are likely to throw in a few ringers, and this not infrequently happens. I would point out that fat necrosis may cause considerable difficulty, both grossly and microscopically. A sclerosing adenosis is a lesion which in permanent section may provide a great deal of difficulty in differentiation. Such situations as the finding of some parasite under the skin has caused us a great deal of concern at times. For example, if your patient has been to Japan, particularly, we may find a very peculiar lesion which on section may be revealed as a paraffinoma. In Japan, as you may recall, many of the military dependents had paraffin injected under their breasts for cosmetic purposes and we are still seeing these in the laboratory. Now, I've given you a benign report on this frozen section. What are you going to do with it?

Dr. Hawk: I'm very glad that you said that

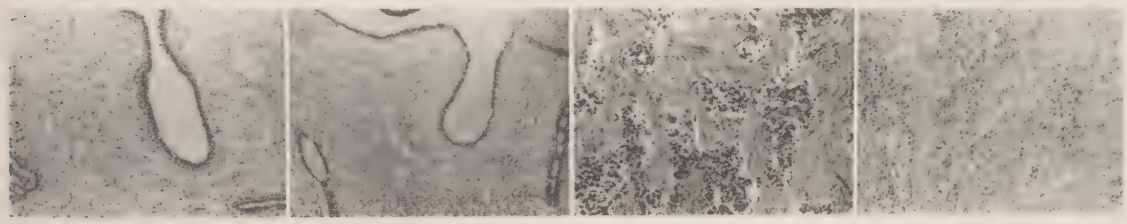


Fig. 1 Fig. 2 Fig. 3 Fig. 4

this lesion, this hypothetical one, that I've given you is benign because Dr. Pettit is going to talk to us about the treatment of the malignant ones. If this were a benign lesion, then certainly the only thing that I would do after excision of it would be to close the wound and we'd probably let the patient leave the hospital the same afternoon or the next day. The patient would come back for follow-up examinations and would be carefully instructed in regard to breast self-examination also. Now, (to patient), fortunately we did not find anything in your breasts but I do think that you should learn to do a complete breast self examination yourself and I would like to give you a booklet which will help you in doing this examination. It is entitled *Self Examination of the Female Breast,* and it is put out by the Cancer Bulletin Organization in Houston, Texas. We will show you only a few pages from it but it does demonstrate the method of doing a complete examination of the breast for the patient. Now you will recall that I examined you sitting up first. Do you think you can do exactly the same thing? You could sit in front of a mirror, go through the maneuvers which I did and look for any asymmetry, any dimpling, or any evidence of any lumps in the breast. Then you can lie down just as you are now, you can put your arm above your head and you can carefully palpate with the flats of your fingers the various areas in the breast. I think you can see that if there were any lumps in the breast, you would feel them. You have to be systematic about it and have to cover all areas of the breast. You would of course do this on both sides. Also you must feel under the arm, and you want to let your arm relax as much as possible, when you feel the axilla or the armpit. You would also feel above your shoulder blade, so that you could be sure, and between your collar bone and your shoulder blade to be sure that you don't have any lumps in this area. Of course, we don't expect you to find any there and you probably won't find any in your breasts. This should give you a certain amount of reassurance to check yourself each month. Now I might say that the American Cancer Society has a movie on breast self examination that has been shown to many women's organizations throughout the state and I think that if you ever have an opportunity to see this movie, it would be worthwhile for you to go to that meeting. Thank you very much for coming to be on this program.

Dr. Groom: I understand that statistically most of the lumps in the breast are found by the patient rather than the physician.

Dr. Hawk: I think that is undoubtedly true. I personally have found very few myself, although I know that many of them have been found by family physicians who have done complete examinations on their patients.

Dr. Groom: Certainly it is incumbent on us, from what you've said this evening to make a very thorough examination. What do you regard as a minimum examination of the breasts as part of a routine physical?

Dr. Hawk: I think that what I've done today is really a minimum examination. If you're going to examine the breast, you should do it completely and not just half-way. It takes only a few minutes. I would say that in two minutes you could examine the breast quite completely and can also probably demonstrate to the patient how to examine the breast in that length of time. I might say that I did not complete a general physical examination, but it goes without saying that when a patient comes with a lump in the breast, you don't examine just the lump in the breast. You have to examine the patient completely for any other evidence of disease.

Dr. Groom: And have a low threshold of suspicion for a lump in the breast. We have been talking about inspection and palpation. Now as to other methods of examination that, shall we say, go a little deeper. Dr. Pettit, what does radiology have to contribute to the diagnosis?

Dr. Pettit: X-ray examination of the breast is not exactly new. Some radiologists were advocating it back in 1921. Gershon-Cohen in Philadelphia has been preaching x-ray examination of the breast for the past 20 years at least, but it wasn't until last year when Egan at Houston, Texas, reported a review of 1000 breast x-ray films that real interest was stimulated in this as a method of finding new lesions

and suspected lesions, and in determining the nature of lumps that were apparent. In his 1000 cases, Egan found 238 carcinomas. He missed two. The accuracy of this survey was 98%. This is rather fantastic. I just didn't believe that any, and I'm still not sure, that any form of diagnosis is 98% correct. However, this was enough to stimulate us to see if we couldn't develop some degree of accuracy in this examination. During the last six or eight months we have done approximately 150 breast examinations at Roper hospital and at the Medical College. Most of this has been done by Dr. Carlisle Hewitt, our chief resident. We have been studying the films that we have made using industrial film and Helen Engerby's textbook on *A Comparative Anatomy and Pathology and Radiology of the Breast*. Then we have been following these, looking at the surgical specimens and correlating the final result with the impression we had to begin with and finding where we made our mistakes when we did. This is the method of examination. The breast is placed on the table with the cardboard film underneath, the x-ray tube over the breast, shooting down with a lead plate under the x-ray film to protect the gonads from the x-rays going through. The next film is the side projection of this examination. This is with the patient turned obliquely, the breast is flat on the film, the x-ray again being transmitted vertically.

This is an x-ray film of the axilla to see if we could pick up any areas of increased density that might indicate metastasis. Here are the criteria that we use in diagnosis of carcinoma of the breast by x-rays. A tumor is quite apt to be denser than the normal tissues found in the breast. The benign lesions are smooth, sharp, well circumscribed. The carcinoma may have a smooth border around most of it but almost invariably it will show one part of the contour of the lesion as an area that is irregular, with spicules radiating out from it into the rest of the breast and perhaps with large tentacles. Calcification is a very important thing. Gershon-Cohen and Ingeby found that approximately 30% of their cases of carcinoma of the breast contained a



DR. PETTIT

specific type of calcification. This was a very fine granular sand-like calcification, generally ranging around the size of a pinpoint. Other calcifications are not indicative of carcinoma and we shall show some examples of them. The contour of the breast is not so important, that is the distortion of the breast outline by the contraction of the tumor. More often that will be evident clinically to the naked eye.

Skin thickening is quite common in carcinoma of the breast and if the breast shows thickening of the skin over the entire circumference, then we have a very strong probability of carcinoma. Abscesses may also produce edema of the skin and so thickening of the skin but it is not apt to be over the entire breast area, just over the abscess itself. Nipple changes, again that is something that is generally seen clinically in the advanced lesions, but sometimes we can demonstrate the nipple changes on x-ray before they are so impressive clinically. Normal structures are displaced evenly by the benign lesion and are compressed and invaded by the spicules and tentacles of the carcinoma. That is a very important sign. Tortuous vessels are quite often found in the neighborhood of a tumor and sometimes they are most impressive in their size.

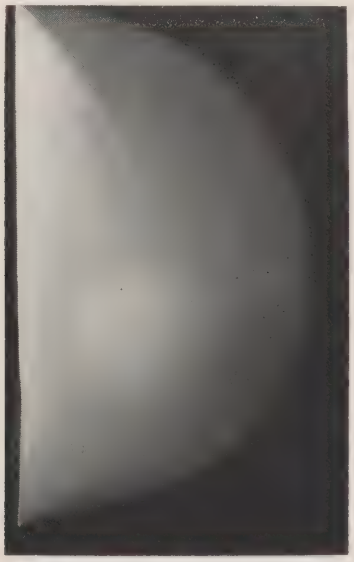
This first film is of a normal gland of the breast. It's relatively even in density, just

slight variations throughout the entire gland. The nipple is almost in tangent but not quite, and we can follow the trabeculations of the duct system. The skin is well outlined here and it is of normal thickness. We have some calcifications that are coursing irregularly through the breast. These are not the calcifications that we see with carcinoma. These resemble vessels and that's exactly what they are. Next is a relatively normal breast. We have a fluffy opacity but there are no spicules coming out from it. The architecture of the breast is naturally distorted. This is adenosis, a benign lesion.

Here we have a breast just beyond puberty and this can give us quite a bit of trouble because the breast contains very little fat, chiefly made up of fibrous tissue; there are very few glands in it too, and a carcinoma in this breast would be or could be very difficult to pick up. Here we have a well defined opaque area. The borders are smooth, and it does not seem to have any spicules. The trabeculi are displaced but evenly so. This is a benign fibroadenoma. This next slide shows an abscess which has no marked thickening of the skin in the region of the nipple, dense calcification extends down toward the base of the breast. It does not have any spicules or any large tentacles extending out from it. Here we have another well defined opacity and we thought that this was a benign lesion, another fibroadenoma, but when this was removed it was found to be a carcinoma. Now looking back you can find a few spicules down here that perhaps should have led us to be more cautious in diagnosing this as benign.



"Flame" density extending from thickened skin around nipple towards base of breast. Abscess.



Dense mass in the base of the lateral aspect of the breast. The radiating spicules are diagnostic of carcinoma.

This next slide shows thickening of the skin throughout the entire breast and then looking closely down at the base of the breast we can find dense spicules radiating from the base. This is a case of inflammatory carcinoma. Just in the last several days we've had some more x-ray films that are rather specific. Here is a well defined calcification, the architecture of the breast is normal all around it, there is no thickening of the skin margin. There is nothing here to indicate that this is a malignant lesion. This type of calcification contrasts to the fine grains of sand seen in carcinoma, and is more often seen, or is seen in abscesses and in fibroid adenoma. Occasionally, that type of calcification will appear in mucoid carcinoma, but there is no sign of anything except a calcified mass in this particular patient. This next film is a lateral projection of the same lesion and again we find no thickening of the breast

tissue adjacent to the calcification. We feel that we are quite safe in a diagnosis of fibroadenoma. This other one is entirely different. Here we have an opacity with fine spicules radiating out from its margin. This one has not undergone biopsy yet, but we feel that we are quite safe in saying that this is carcinoma. This is typical primary operable breast cancer.

Dr. Hawk: Dr. Urban, What is the current salvage rate of primary breast cancer?

Dr. Urban: At present we salvage about half of all primary cases at five years. As you see, on this slide, the salvage is 54.4% at five years and 33.8% at ten years. Now this is actually twice the salvage rate which was originally reported by Halstead in 1907 after he, as well as Willy Meyer, introduced the radical mastectomy procedure. Prior to the invention of this procedure a five year salvage of breast cancer was a real rarity and such patients would be reported in the literature—it was so unusual. This doubling of the salvage rate is due primarily to the fact that we are getting earlier cases in which the disease is more apt to be confined to the breast and regional nodes and not already spread systemically. Now—you don't get this sort of result unless you do this sort of procedure. The whole concept of the radical mastectomy is to remove the primary tumor and surrounding breast tissue together with the regional nodes of the breast in continuity. In order to do this we must take an adequate skin margin about the tumor, remove all the breast parenchyma which necessitates thin skin flaps, and we have to clean out the axilla removing all the lymph nodes and fatty tissue and leaving only the neuro-vascular bundle as we see in this case. Unfortunately, we often see a patient come into the clinic with this appearance, with a not saying "she had a radical; would we give her x-ray therapy?". Well, this patient obviously never had an adequate radical mastectomy, there are thick flaps, there is no axillary dissection and here is a local recurrence. This is the sort of procedure that fails to salvage a number of patients who could be saved by an adequate operative excision.

We must admit that most of our recent gains



Large mottled calcification typical of those associated with fibroadenomas.

in salvage rate are due primarily to early diagnosis. By combining early diagnosis with more adequate surgery and x-ray therapy we are most likely to improve our salvage rate at present. At best all current methods of primary therapy are local attacks on the tumor and its regional lymph nodes and all fail when the disease progresses beyond this area. This slide demonstrates quite definitely the improved salvage of the early cases. If you look at the upper group here—this is the overall group—200 patients with primary operable breast cancer, fairly good material—55% axillary involvement. The overall survival rate is 66%, the five year clinically free of disease figure is 58%. Now, if we divide this group into two sub-groups—the first in which we diagnosed carcinoma clinically by clinical signs—inversion of the nipple, skin retraction, hard axillary nodes, etc. In this group which comprises a rather late stage of cancer our salvage rate was 63% at five years and our five year figure free of disease 53%. Let's look at the last group—the early group. These are patients in whom the cancer was found during a routine local excision of an apparently benign lesion. Following frozen section discovery of the cancer radical mastectomy was done at the same sitting. In this group we had a very low incidence of axillary node metastases—36%. Our salvage

rate was 73% and our five year survival rate free of disease 70%. This is what we should be able to achieve in the overall attack on breast cancer if everyone involved—the patient, the physician, the surgeon, the radiologist would use all methods available for diagnosis and therapy with utmost efficiency. We would still lose 30 or 40% but this is far better than our current salvage rate which in the overall group of primary breast cancers is only between 40 and 50%. Now, in addition to finding the patient at an early stage, which is really the most important factor with our present means of therapy the other means of improving results are represented by the various methods of treatment which have been proposed during the last decade to control disease more adequately in the initial local attack. All are variations of the same theme—an attempt to destroy or remove the primary tumor together with its regional lymphatic drainage before the patient has systemic disease. The basis for this is the anatomy and natural history of this disease.

Turner-Warwick in England has demonstrated very thoroughly that, in the average breast, three quarters of the lymphatic drainage goes to the axillary nodes and one quarter to the internal mammary nodes. Almost no drainage goes to the opposite axilla or to the opposite internal mammary chain. Unfortunately, drainage continues along these two pathways to the base of the neck and there enters the confluence of the large veins and becomes systemic.

Two opposing schools have arisen in the last ten years based upon the same clinical findings. McWhirter and his group maintain that we should do a partial simple mastectomy only. He believes that he can do a better job in controlling lymph node disease in these patients by radiation therapy. On the other hand we have the more aggressive surgeons who feel that if radical mastectomy does a good job in the axilla it should also do a good job with the internal mammary chain. The rationale here is to extend the scope of the operative procedure in order to remove a wider area of drainage of the breast hoping that in so doing we will remove early metastases in this additional area before they have a chance to spread. When all primary cases—primary operable, primary inoperable, borderline were included—in 1947 McWhirter obtained a five year salvage rate of 41%. Subsequently, in later years, he averaged about 42%. On the other hand, at Memorial, at the Mayo Clinic and in the Saskatchewan Clinic as well—evaluating similar material treated by radical mastectomy with supplementary x-ray therapy, that is, all primary cases whether operable, inoperable or borderline—the five year survival rate varies between 49 and 52% during the same period of time. This is 7 to 8% better and would certainly indicate that the McWhirter technique instead of being a step forward, is really not as good as the classical radical mastectomy supplemented by x-ray therapy.



DR. URBAN

Dr. Groom: Would you care to say something about x-ray therapy at this point, Dr. Pettit?

Dr. Pettit: I think we should ask Dr. Urban when he would send the patient to the radiologists for x-ray therapy after the operation.

Dr. Urban: Well, in principle the decision to give x-ray therapy is very simple—it is given in order to control further local extension of disease into the regional nodes. Obviously there is no point in giving x-ray therapy to a

patient who is free of disease. On this basis, if an adequate radical mastectomy is done and all nodes are negative, and the lesion is in the outer half of the breast there is no indication for local x-ray therapy. On the other hand if axillary lymph nodes are positive or if an extended procedure has been done and the internal mammary chain is positive, there is a much greater possibility that further extension of disease is present in the supraclavicular nodes. In this case x-ray therapy is indicated, covering the lymph nodes in these other areas. If we do a radical and find positive axillary nodes we usually use a "hockey stick" shaped port covering the base of the neck and the internal mammary chain area in continuity and administer a tumor dose of approximately 3500 r using supervoltage therapy. I understand that you use a similar technique.

Dr. Pettit: We use the same technique as far as the fields are concerned. But as for dosage we go a little higher, we go to 5000 r and up.

Dr. Urban: To get back to the varieties of less orthodox methods of treatment of primary breast cancer. We have the extended radical mastectomy. At Memorial we have devised a procedure that includes the internal mammary chain in the primary operation. We apply it mainly to medial half and central lesions since they are more likely to metastasize to the internal mammary nodes. Wangensteen in Minnesota has devised a very radical attack on breast cancer and other people in Europe—Handley in England, Dahl-Iversen in Denmark, Margottini in Italy, all have developed varieties of operations extending the scope of the radical mastectomy procedure. We, at Memorial, have operated on about 450 patients and found that approximately 50% of our patients have axillary node disease and about one third showed internal mammary disease. With this group of patients we obtained a five year salvage of 66% and a five year salvage rate clinically free of disease of 60%. This compares rather well with an anticipated salvage rate of about 50% utilizing radical mastectomy alone. In extending the scope of the primary operative procedure we are more apt to show a significant gain in reducing local recurrence since this is still a local attack. We are less likely to show very marked increase in overall salvage rate since all local attacks are stymied by the presence of systemic disease.

This slide demonstrates the local recurrence rate. The main figure to notice is the one concerning medial and central lesions. These lesions show a much higher local recurrence rate than do lateral ones. The overall local recurrence rate with radical mastectomy is about 13%—with inner half lesions it is almost twice that—23%. With lateral lesions it is only about 4%. Now, by extending the scope of the operative procedure we have reduced the local recurrence to about one third of what we would have anticipated following a straight radical mastectomy. Certainly we have nothing to be complacent about with these various methods of treatment for breast cancer. We must admit that we are attempting to control a disease which becomes systemic only too quickly with a local attack and that we are bound to failure only too often.

Another angle that might be discussed regarding primary therapy of breast cancer is the so-called "triple biopsy". As you know, some individuals believe that if you have a lesion in the inner half of the breast or a lesion with rather extensive axillary node involvement patients should be explored by biopsy of the internal mammary nodes and the nodes in the apex of the axilla. Prior to doing this the patient is surveyed to rule out any other systemic metastases. These individuals believe that if disease is found in the internal mammary nodes or the apex of the axilla the chances of salvage are so low that these patients should be treated by x-ray therapy only. We don't hold to this theory and we have included these patients in our material. Includde in the group that we have subjected to the extended radical mastectomy we had 91 patients who would be considered inoperable on the basis of finding nodes positive in the internal mammary chain or the apex of the axilla or both. In this group we had 46% alive at five years and 41% free of disease. Now these figures are not very good but they are

certainly not too bad either. On the other hand, in the group that would be considered operable—with a negative apex of the axilla and a negative internal mammary chain—we had an excellent five year salvage rate—79% and 71% free of disease at five years. The triple biopsy really differentiates between a relatively good group of patients and a group with a relatively poor prognosis. I don't think we can neglect these latter patients, however.

We must admit that our tools for treating breast cancer are limited. We succeed only when we find the patient sufficiently early, with disease confined to the breast or regional nodes and when we destroy or remove all disease either by surgery, x-radiation therapy or both. When disease is present beyond this region we eventually lose the patient. Again we cannot be complacent about our achievements and must admit our failings. However if we utilize the means that are at present available for diagnosis—mammography, cytological examination of nipple discharge,—and continue to have a high index of suspicion of any persistent mass in the breast and then apply adequate surgical and radiological attacks on this disease we certainly will improve the salvage rate from its present level of approximately 45% to somewhere about 60%. We desperately need an effective systemic treatment.

Dr. Groom: Now about those that are inoperable. Dr. Hawk, what other therapeutic approaches do we have for advanced disease carcinoma of the breast?

Dr. Hawk: The first thing I think we should say is that the treatment of advanced disease is different in the pre-menopausal patient and in the post-menopausal patient. We are fortunate to have a patient who has kindly come up from Charleston who demonstrates most of the features of the treatment of the pre-menopausal patient. Will you come right here to answer some questions and tell the members of the audience about your case. This lady was 33 when she was first seen in our Cancer Clinic and she had had a radical mastectomy two years previously in August, 1957. In August 1958, she had her first recurrence, a local recurrence in the opposite area and the treatment for this was x-ray therapy.

I think we can say that for advanced breast cancer the first thing that we think about is x-ray therapy to the local areas of metastatic or recurrent disease. She later had a recurrence in the left supraclavicular area and again had x-ray therapy. Subsequently in October, 1959, she had a pain in the lumbar spine and she had the next mode of treatment which in this case was bilateral oorphorectomy and she was still menstruating at that time. Now some people add thyroid extract to this but it is not essential in most people's minds since there is some question as to how useful thyroid extract may be.

About a year later she was having difficulty again. This was in September, 1960, and at this time she was given androgen therapy in the form of testosterone. Would you like to tell us how much help you got from that first series of injections. Do you think it helped you a great deal?

Patient: It certainly did. At the time that I had that I was having a lot of pain in my back and difficulty in walking. It helped me for . . .

Dr. Hawk: It didn't last too long though. Is that right?

Patient: No.

Dr. Hawk: Well, after about four or five months she had trouble again and last spring she got into very serious difficulty and we started her on another form of treatment which was at this time 5-fluorouracil. Any other cytoctoxic agent could be used and I think we might say that some people would put this before bilateral oophorectomy. I personally would not. Some would put it before androgen therapy, some would put it just where we did, after the androgen therapy in this sequence. How did you respond to that?

Patient: At the time that I started, I was having difficulty in walking, I'd lost the use of my right arm, but since I've been on this treatment, I've regained the use of my arm and I can walk pretty well now.

Dr. Hawk: And you feel pretty healthy at the present time?

Patient: I certainly do.

Dr. Hawk: Well, she has certainly improved

a great deal. Dr. Pettit, could you show us x-ray films in her case.

Dr. Pettit: Here are some of the representative films. This was a film made back in January of 1960, and here we see osteolytic metastases through the bones of the pelvis and in the lower part of the lumbar spine. The last film we have was made on November 16th and you can see that the osteolytic cystic lesions are filling in very nicely. This film shows the extent of the disease with the compressed vertabra, the multiple metastases throughout the ribs in the scapula and in the humeri. Next are two films of the skull. This was a film before the 5-FU was used. You see all these osteolytic metastases and then you can see how well they've filled in, particularly in this region above the orbit.

Dr. Hawk: I think we may add that, in the pre-menopausal patient, adrenalectomy or hypophysectomy must be considered another mode of treatment which will be used in selected cases.

Dr. Groom: I should like to ask Dr. Urban in conclusion, what promising new avenues of research are on the horizon?

Dr. Urban: Well, there are two main aveenues of research concerning treatment of breast cancer on a systemic basis. One is the continuing search for more selective chemicals to use for chemotherapy and the other is an approach through virology with the understanding that possibly viruses are involved in the development of these tumors. If this is so then some means may be found for developing tissue and body resistence to these lesions.

Dr. Groom: What do you think about adjuvant chemotherapy at the time of surgery?

Dr. Urban: I believe that the dosage usually given is so small that one can't anticipate too much response. The results reported so far are rather premature, although very promising. I think we still have to wait a number of years before we can really evaluate them.

Dr. Groom: Here in South Carolina we are very fortunate in having in many areas of the state excellent facilities for pathologic and radiologic examination, as well, of course, as for surgical treatment. Probably in future years with the development of some of the approaches and techniques which have been discussed this evening some of those statistics which we cited at the opening of this program may be drastically modified—for the better. Let us hope so.

Dr. Groom: I think one of the most interesting and informative parts of these programs has been the question and answer period. And we come to that now—the portion in which you, the viewers, have an opportunity to call in questions to the educational television studios here in Columbia for our panel to answer.

Now earlier we talked a little about the treatment of the pre-menopausal patient with advanced metastatic carcinoma. How about the treatment of the post-menopausal patient? Dr. Hawk, would you care to say a little about that while we're waiting on the telephone calls.

Dr. Hawk: Well, Dr. Groom, we use this little device in the pre-menopausal patient and I think we can do the same thing with the post-menopausal patient. First of all, x-ray therapy still must remain the treatment which we will utilize primarily when we get a recurrence in a patient, either locally or in metastasis at a distant area. Now a few years ago we thought that the post-menopausal patient should be treated primarily by estrogen therapy if we tried to alter the hormonal environment in the patient. More recent statistics indicate that androgens are quite effective in the elderly patient, particularly ten years or more post-menopausal. So I personally would put androgen therapy as the next order of treatment, even in the post-menopausal patient. Then we would use estrogen therapy if androgens failed.

Frequently we take the patient off of androgens with a period for withdrawal remission and then try them on estrogen to see whether they get any effect. Now somewhere along the line at the present time we have to consider chemotherapy with 5-fluorouracil or one of the other cytotoxic agents. Perhaps you'd want to put it, if you're a 5-fluorouracil enthusiast, right after x-ray therapy. Perhaps

you would try androgen first and then 5-fluorouracil. Perhaps you would put it directly after estrogen. Also one can use in the post-menopausal patients either bilateral adrenalectomy or hypophysectomy or both. We have used adrenalectomy to a limited extent; we have not done any hypophysectomies at Charleston and our enthusiasm for this is perhaps not as great as in certain other centers. Then after you have run out with that, there arises the question of using large doses of corticoids—prednisone, or decadron with or without thyroid extract. Dr. Urban, would this be about what you would do?

Dr. Urban: Approximately, with some reservations. We would prefer to use androgens in the post-menopausal patient who is less than five years post-menopausal. However, in patients who are more than five years post-menopausal we would reverse this order and would prefer estrogens, following x-ray therapy. Another thought—I think we would use 5-fluorouracil as the last treatment rather than among the early group. 5-FU is toxic. I think the response to hormonal variation is greater and less traumatic than the results of our present chemotherapy.

Dr. Hawk: Dr. McIver happened to be one of the persons interested in 5-fluorouracil out in Wisconsin early in the game. I wonder if you want to say something about 5-FU. Are you enthusiastic for it?

Dr. McIver: Only if the tumor has already given indications that it will not respond to hormonal therapy. It is quite well recognized that patients can be divided into one of two groups. Either they are hormone susceptible or not hormone susceptible, and if they do respond to hormone therapy, they may have a very spectacularly beneficial result. However, if the tumor is not hormone susceptible, we now have a different, a new opportunity to produce real benefits in the form of 5-fluorouracil or other drugs of this kind.

Dr. Groom: Do these tumors vary a great deal in their susceptibility to this drug? Is it at all predictable?

Dr. McIver: I believe that up to the present time it is quite impossible to predict accurately whether a tumor will respond to chemotherapy or not. Although there are some suggestions, I don't believe these are useful at the present time. Maybe Dr. Hawk has in mind something different.

Dr. Hawk: I don't think you can predict them at all. You just have to try them and if they work, you're very happy about them; if they don't work, why you have to try something else.

Dr. Groom: Here's a question that just came in from Dr. West in Camden. "Explain about level of lymph nodes which Dr. McIver referred to." Do you know what this refers to, Dr. McIver.

Dr. McIver: When we examine a specimen in the Pathology Laboratory, with the aid of the surgeons having marked the specimen for us, we think in terms of the lowest level being level one. That is the level lateral to and below the lateral margin of the pectoralis minor muscle. Level two is a very much smaller area and this is that level which is behind the pectoralis minor muscle. Level three in the average specimen is even smaller, very small, and this is that amount of fat and lymphoid tissue which has been removed from the area medial to the medial edge of the pectoralis minor muscle. By dividing a specimen into these three areas, we are then speaking a universal language. Level one, the lowest, level two, the mid area, and level three the high area. If these areas are not accurately marked, it is impossible to locate them accurately and we simply refer to the highest area, the middle area, and the low area.

Dr. Groom: Here's a question from Spartanburg, from Dr. Hammond. It's very relevant to some of the discussion this evening. He asks about treatment of the late post-operative edema of the arm. I think our surgical colleagues ought to handle this. Dr. Urban, do you get edema of the arm in New York following radical mastectomy?

Dr. Urban: Oh, definitely. The incidence of significant edema is somewhere around 5% I would guess. Lymphedema is caused by inadequate lymphatic drainage of the area involved. When one does a good axillary dis-

section and then supplements it with x-ray therapy he probably destroys the major portion of the lymphatic vessels draining the arm. It is to be expected that a larger proportion of obese patients will develop edema since they have a larger dead space in the subcutaneous tissue where edema occurs. Now there are many methods to combat edema and the reason there are so many methods is that none of them is very good. The older methods approach this subject by attempting to increase lymphatic drainage in the arm. Recently an instrument called the Circulator has been devised. This is similar to a large sleeve and essentially consists of a series of blood pressure cuffs. The arm is placed in this sleeve and pressure is applied graduating from the lower portion to the more proximal areas—affording massage and pressure on the arm. If the patient uses this machine properly for one or two hours a day, at times, and particularly with early edema, the situation will be improved. Some time ago we were impressed with the thought that edema followed fibrosis in the axilla, which caused contraction of the skin about the upper arm and acted like a constricting garter. We treated a few patients by splitting the skin posteriorly at the axilla, separating the skin widely and swinging a large, full thickness flap from the back into the resultant defect. Several patients had a fairly good response with some diminution of edema but in no instances was this completely satisfactory. Recently, we have treated some 20 patients by inserting monofilament nylon sutures extending in the subcutaneous tissues from the knuckles to beyond the margins of surgery and x-ray therapy into the free tissues, hoping that the channels which were produced about the monofilament would afford passage for lymphatic fluid to normal tissues where it would be carried away normally. In a few patients we obtained rather dramatic results but in most the results were equivocal.

Dr. Groom: Dr. Hawk, do you have any other discussion?

Dr. Hawk: Well, there are a few people who have tried a stellate block for this with some degree of success. I believe that good wound healing does play a part in preventing this edema and if you can get the wound healed quickly, most of the time edema is not a problem. Also, I do think it helps to keep the arm wrapped during the period of healing so that you prevent it until the time when some degree of lymphatic drainage and circulation has been re-established.

Dr. Groom: We have a great many questions coming in. Here are several from Greenwood. Dr. Bill Trotter brings up an interesting point which I think we might direct to Dr. Pettit. "Would you mention something about the possible bad effects from surgery prior to x-ray treatment of the inflammatory carcinoma of the breast?"

Dr. Pettit: In Charleston inflammatory carcinoma is not treated surgically. We feel that that just speeds up the malignant process and almost invariably inflammatory carcinoma patients are sent to us directly.

Dr. Hawk: I certainly would agree with that. Inflammatory carcinoma in the first place is bad news for the patient in most cases and I believe that Dr. Treves at Memorial has done quite a study on inflammatory carcinoma and his feeling has been that radiation therapy is probably the best modality. Perhaps in the post-menopausal patient, estrogen therapy may be helpful in some of these patients.

Dr. Groom: Dr. Urban, you're not operating on them at Memorial now, are you?

Dr. Urban: No, we aren't. We had only two patients we thought about operating on and before committing ourselves, we did scalene node biopsies in these fairly early lesions and in both instances the scalene nodes were positive, although they weren't palpable clinically. One other angle in this field. I think the optimum therapy here is initial supervoltage therapy covering the entire breast, extending way beyond the palpable area of tumor, covering the axilla, the base of the neck, the mediastinum. Later on, if the disease may be controlled for awhile or if it is not controlled initially, these patients do surprisingly well with hypophysectomy or adrenalectomy. In our

series at Memorial I think over fifty percent showed remission with adrenalectomy, which is hard to understand and some were of rather long duration.

Speaking of a wide field, sometimes we have had to go all the way back to the spine to get a good margin.

Dr. Groom: From Dr. McClain in Greenwood and from Dr. Pegler in Darlington and from Dr. Snyder in Sumter come questions all wanting to know something about the treatment of cystic mastitis. I think that would qualify as a lump in the breast. Dr. Urban?

Dr. Urban: Yes, I think they are referring to generalized cystic mastitis which we see so often, which alarms so many patients and which probably is not of too much significance —even though the incidence of breast cancer in these patients is probably somewhat greater than in the general population.

I think the first thing is to be sure that it's cystic mastitis. There are two ways to prove this, either by biopsy or by constant surveillance of the patient. I believe that cystic mastitis is probably caused by excessive estrogen stimulation of the breast. You get changes in the breast which persist through the period in some patients and are similar to the changes that occur in most women during the premenstrual phase when the estrogen level is so increased. Personally I treat most of these patients with massive doses of vitamin B complex. The rationale here is to stimulate liver metabolism of estrogen. One can also put them on progesterone (corpus luteum hormone) which supposedly neutralizes the effect of estrogens on the breast. Oftentimes these patients are improved, the lesions disappear, but really it's very difficult to evaluate this because often cystic mastitis without any therapy at all will also clear up. The important thing is to be sure that we are dealing with cystic mastitis and to follow the patient closely.

Dr. Groom: Dr. King in Darlington asks the question of Dr. Hawk: "What is the average length of time for metastasis of breast carcinoma", and, of Dr. Pettit she would ask, "Is there any radiation danger due to x-ray diagnosis?"

Dr. Hawk: Well, I think that I can answer the question by saying that I don't know. There is no way to know when a cancer starts. I think there's no way to know when a given cancer is going to metastasize. MacDonald in California has talked a great deal about biologic predeterminism, which is simply a way of stating that some cancers are bad and some cancers are not so bad. We can't tell which ones are going to grow rapidly, which ones are going to spread rapidly, and I don't think you could predict this even with a histologic section of the given cancer with any degree of accuracy. You can't tell whether one is going to metastasize rapidly or is going to metastasize more slowly.

Dr. McIver: I would like to make one comment in this direction, and that is that these patients may go a very long time before the metastases appear. We have seen patients who've gone 15 years, 18 years, 22 years before metastasis appeared. We've also seen patients who have run their course in three to four months from the time carcinoma was suspected. There is a tremendous variation in the biologic potential of these lesions, but for any individual carcinoma regardless of these theoretical possibilities, for any individual case, the sooner you treat it, the more likely you are to have got to it before it has metastasized.

Dr. Groom: This question from Dr. Fuller in Clinton, I'm certain would not have occurred to any of the members of the panel, but it's a relevant one. "What routine investigation would you follow in a pubescent male, say 11 or 13 years old, with unilateral gynecomastia?"

Dr. Urban: Gynecomastia is a peculiar lesion and in the great majority of gynecomastias which are investigated, all investigations run up a blind alley. You never find any real abnormality in the endocrine system to pin the gynecomastia on. It's very likely that in a youngster of this age, I possibly would not subject the child to a tremendous battery of endocrine investigations, but would follow the child with examinations possibly every two or three months. Almost invariably in a child of this age, within six to eight months the lesion disappears spontaneously. So that,

although theoretically one should investigate these, honestly, we don't know what to look for as a basis of cause.

Dr. Groom: Well, this question from Dr. Helen Weilland in Lancaster is somewhat along the same lines. "Should all chronic mastitis lumps be sent somewhere or investigated further?" Would you agree to that?—or can we generalize?

Dr. Hawk: I think you have to be practical in this problem. You certainly can't take every lump out of every breast you see in the office. You'd be doing mastectomies on all patients. If one is reasonably sure that the lesion is benign, and has good control of the patient and is assured that the patient will return for routine thorough examinations, he can certainly follow a lot of patients with chronic cystic mastitis without surgical intervention. On the other hand if any lesion appears as a dominant mass—more firm, different from the rest of the tissues—this should be excised for further inspection. In some of these patients mammography is of use as a corroborating means of diagnosis. In other words if a patient has multiple lumps in both breasts, we follow the patient, but we're very unhappy because they all look benign but you can't prove it without taking them out. If mammography is done and the radiologist is satisfied that this is benign, it gives you a little better sense of reassurance that you're not missing the boat; but with all these patients the main thing is to follow them as long as these masses are present.

Dr. Groom: And getting back to mammography, we have that question about the potential danger of x-ray. Would you rise in defense of x-rays, Dr. Pettit?

Dr. Pettit: I don't think there's any danger there as far as radiation is concerned. The greatest danger I can see is that heavy cannon dropping on the patient's breast.

Dr. Groom: I trust you don't drop it very often.

Dr. Pettit: Not very often. I admit the theory that anybody has been able to measure the dose that the gonads get, nobody has reported any measurement and I think that's probably due to the difficulty in obtaining a dose that is so minute as that one.

Dr. Groom: Has anybody reported any dropped cones?

Dr. Pettit: No.

Dr. Groom: Still on cystic mastitis, this one from Dr. Geiger here in Columbia. "Do you think patients with cystic mastitis are predisposed to carcinoma of the breast?"

Dr. McIver: This question, of course, would be answered in different ways by different persons. I need not pretend to be unprejudiced because I just happen to believe that persons with cystic mastitis have a somewhat increased likelihood of developing carcinoma of the breast. On the other hand I'm not an alarmist in this area because I personally believe that at some time almost every woman has some degree of cystic mastitis. In the final analysis I would say that in those patients that have cystic mastitis, or mastoplasia as we like to call it, and who show very prominent proliferation, I do believe that these people are more likely to develop carcinoma. If however, the tumor is primarily fibrous and not proliferative then I believe the likelihood of increased incidence of carcinoma is very small.

Dr. Groom: Coming once again to the treatment of the patient with advanced disease, Dr. John Timmons poses the question, "please discuss prophylactic oophorectomy in carcinoma."

Dr. Hawk: This question of prophylactic oophorectomy simply relates to whether or not at the time you do a radical mastectomy for carcinoma, you decide to remove the ovaries or carry out x-ray castration in the patient. It was started a number of years ago, first by Dr. Houstlen in Richmond, and it has been tried in many places. It is being studied on a nationwide basis at the present time through a cooperative venture of a number of groups or institutions. Patients receiving radical mastectomy for carcinoma of the breast are randomized; some are castrated and others are not. My personal feeling is that you can probably achieve as much in the long run by waiting until the patient shows evidence of advancing disease before carrying out castration and that by waiting you do avoid a good

many unnecessary castrations and the psychologic implications of such castrations. I personally am not in favor of prophylactic castrations at the present time.

Dr. Groom: A physician in Camden asks the question, as to the basis of the rationale for the use of thyroid extract in the treatment of carcinoma. Do you use thyroid, Dr. Urban?

Dr. Urban: I don't use it, no.

Dr. Groom: Do you use it Dr. Hawk?

Dr. Hawk: Well, part of the rationale of using thyroid extract is the supposed inhibition of T.S.H. and possibly of other factors from the anterior pituitary. It was started many years ago and recently has been revised in a group from Boston, Henry Lemmon particularly has tried it both with castration and also with corticoid, and whether or not it has any real valuable place, still has not been completely determined. There is another study in which, after castration, some are given thyroid extract and some are given a placebo.

Dr. Groom: This question from Dr. Snyder in Sumter, I think is certainly most relevant. He inquires as to the possibility of spread of a malignant tumor following the use of aspiration biopsy.

Dr. Hawk: I personally feel that the danger of spread by aspiration biopsy is certainly no greater than the danger by incisional biopsy or by excisional biopsy of a large mass. Perhaps a little tiny mass is not as likely to be injured by excisional biopsy although you certainly will be cutting across some lymphatics. A lot depends on how vigorous you are in your aspiration. It also depends on when you do it. If you do it sufficiently far in advance of definitive surgery so that the chance of a little bit of hematoma formation and the associated inflammatory reaction before definitive surgery, then perhaps it may be dangerous. I believe if you're going to do an aspiration biopsy on breast cancer, we prefer to do the aspiration biopsy within 24 to 48 hours of the operative procedure.

Dr. Groom: We have just time for one more question. We discussed this evening inoperable lesions. What are the criteria of inoperability? Dr. Urban, do you have any criteria—any stock criteria—that you follow?

Dr. Urban: Well, you can describe the overall picture very simply but to pin it down to actual factors is very difficult. The only patients who are inoperable are patients in whom the disease is so extensive that one cannot remove it surgically or cure it with local x-ray therapy. In other words, the patient should have systemic disease. Now there's a great deal of variation in different individual interpretation of what is inoperable. We prefer to be very liberal in our criteria of operability because we don't think that we do very much harm in operating on a more advanced patient and we might, we prefer to give the more advanced patients the benefit of the doubt and subject them to radical surgery and x-ray therapy. I think the main area of question is in the so-called combined groups where you have ulceration of a tumor, large nodes in the axilla, or some fixation of the skin, and so forth. Certainly a patient with proved systemic metastasis is inoperable. The questionable group is where you have extensive disease locally and no evidence of distant disease. We could spend a half hour talking on this really.

Dr. Groom: I want to thank our panelists for their discussion this evening: Dr. John Hawk, Dr. Forde McIver, Dr. Harold Pettit, and particularly our guest speaker, Dr. Jerome Urban, who journeyed from New York City to appear on this program. And to our viewers throughout South Carolina, our thanks for your stimulating questions. We hope you will join us again next month.

Clinics of the Month

POISON CASE REPORT OF MONTH

HENRY W. MOORE, M. D.
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Death from Inhalation of Lighter Fluid

Kerosene and petroleum products are widely used in our present day culture. Ingestion of these products not infrequently results in fatal pneumonic complications in young children. Various studies reveal from thirty to fifty percent of involved cases with pneumonitis or pneumonia. Most authors feel that the major hazard of petroleum product ingestion is that of aspiration either directly or secondarily from vomited material. Richardson and Pratt-Thomas,[1] extrapolating from animal experiments with dogs, calculate that more than 500 ml. of kerosene would be required to kill a 50 pound child, if no aspiration occurred, while approximately 2.5 ml. intratracheally would cause a severe illness which would probably prove fatal.

Ingestion of kerosene-like products produce symptoms in the central nervous system and lungs. Central nervous system depression occurs soon after ingestion and varies with amount of ingested substance. Inhalation or aspiration is followed by rapid onset of pneumonitis which may become extremely severe within a few minutes. Death, when it occurs, is from pulmonary insufficiency and failure. Pathologic studies previously reported reveal primarily a severe, necrotizing pneumonia.

The following case report dramatically illustrates the results of inhalation of a relatively small amount of petroleum distillate with sudden death apparently due to severe widespread chemical pneumonitis and resulting fatal pulmonary edema with respiratory circulatory collapse.

A fourteen months old white female infant found a small can of "Red Devil Lighter Fluid" on the kitchen table. In attempting to drink from the adapter end of the can she inhaled a very small amount of the fluid, estimated to be two to three ml. of fluid. Onset of symptoms was instantaneous with severe coughing and immediate onset of respiratory distress and cyanosis. In a brief span of minutes the child developed severe respiratory distress and became cyanotic and was immediately rushed to the nearest hospital. On arrival at the hospital, the infant was deeply cyanotic and had irregular gasping respirations with marked generalized convulsive movements. The child had apparently vomited during her ride to the hospital and started convulsing almost simultaneously. Heroic emergency measures were instituted. Airways were suctioned and cleansed. Oxygen and respiratory stimulants were administered along with artificial respiration. Copious amounts of bloody frothy mucous were suctioned from the patient's upper respiratory tract. Then an endotracheal tube was inserted and the patient was placed in a croupette with moist oxygen. Positive pressure artificial respiration was necessary for some thirty minutes before the patient resumed irregular respiratory movements.

The patient responded very poorly and positive pressure respirations were necessary to maintain pulmonary function. External cardiac massage was instituted shortly before complete circulatory collapse occured. Death ensued approximately 2 hours 40 minutes after inhalation of the lighter fluid.

PROTOCOL (Pertinent Findings)

Lungs: The tracheo-bronchial tree contains some increased mucoid material, but this is not thickened. There is no erythema of the tracheo-bronchial mucosa. The lungs are similar. There is marked pulmonary edema. The changes are diffuse in all lobes.

Tissue Sections: The alveoli are distended and contain a homogenous eosinstaining material, representing edema fluid. There is some associated extravasation of blood. The alveolar blood vessels are dilated. The bronchioles appear normal.

Gastro-Intestinal Tract: The esophagus and stomach appear normal. A small amount of digested milk is present in the stomach, less than 20 ml. The duodenum, jejunum, ileum, and large bowel appear normal. (No notation of petroleum substance in stomach.)

DIAGNOSIS: Kerosene poisoning, due to ingestion of lighter fluid.
A. Hemorrhagic pulmonary edema.

Pathological findings strongly indicate that this infant died as a result of acute pulmonary edema and resultant anoxia. Severe convulsions occurring so rapidly after inhalation of petroleum distillate, would indicate that cerebral anoxia was early and of extreme degree.

Recent reports[2] have indicated possible benefits from parenteral steroid therapy in acute kerosene poisoning. Such reports are yet to be verified by controlled studies. This patient did not receive steroids, however, the course was so fulminating that serious doubts arise as to the value of any type of therapy.

This case again points out the extreme hazards of aspiration of kerosene-like products. The inherent danger of aspiration of petroleum products during stomach lavage would seem to negate any possible advantages derived from removal of such substances. Emetics are certainly contra-indicated in such cases. Gerarde believes in the basis of extensive laboratory studies "that it is highly improbable that a child could accidentally ingest enough kerosene to cause pneumonia of hematogenous origin."

(I wish to thank Dr. A. Frank Harrison, III for permitting me to report this case.)

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1. Richardson, J. A. & Pratt-Thomas. H. R., Am. J. Med. Science, 221:531-1951.
2. Bulletin Nat. Clearing House for Poison Control Centers, P.H.S., Washington, D. C., June 1961.
3. Gerarde, H. W. The Pathogenesis of Pulmonary Injury in Kerosene Intoxication. Delaware State M. J. Vol. 31, No. 9-P276, September 1959.

DERMATOLOGICAL DON'T'S

Kathleen Riley, M. D.
Department of Dermatology
Medical College of South Carolina

Photodynamic Dermatoses—Drug Induced

White, Male, Age 20

HISTORY

Five days previously the patient had an acute upper respiratory infection with fever.

He was given a five day supply of demethylchlortetracycline (Declomycin).

He felt much better and 48 hours previously had joined his golf foursome for an afternoon of golf.

That night he noticed an unusual redness on his face, hands and arms. He thought this was sunburn but the redness developed to an alarming degree.

It was mildly pruritic.

Because of the dramatic change in color, he sought medical help.

PHYSICAL EXAMINATION

The dorsum of both arms, below the short sleeve line and on the dorsum of the hands and fingers showed deep, macular, purplish erythema.

Similar lesions of equal intensity were present on the forehead, cheeks, back of the neck and "V" of the neck in front.

The areas were completely confluent with an ill defined border.

Impression

Acute Photodynamic Dermatoses

From

Demethylchlortetracycline

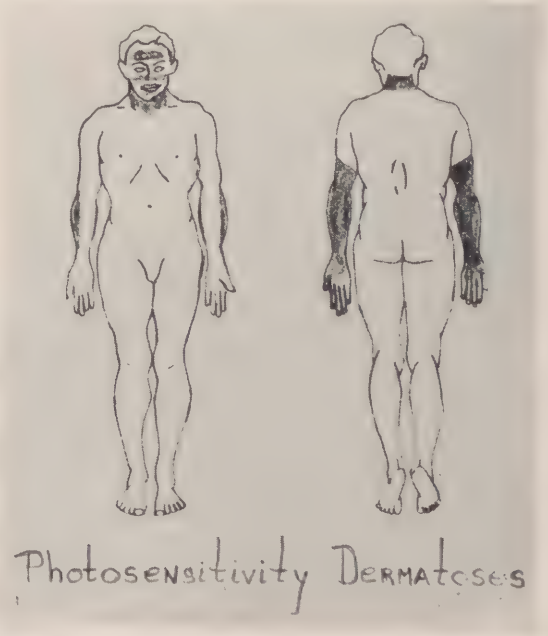
Don'ts

1. Don't fail to take drug history in the presence of acute erythema on exposed surfaces.
2. Don't confuse with contact dermatitis which is very similar.
3. Don't expect erythema to fade in 4-6 weeks.
4. Don't expect residual pigmentation to fade for months.
5. Don't treat vigorously, simple local applications are adequate.

Do

1. Do warn patient to stay completely out of the sun until the eruption has subsided.
2. Do avoid in this and other patients sun sensitizing drugs. These include:
   A. Other antibiotics_.Chlortetracycline—HC (rare)
   Griseofulvin (rare)
   B. Sulfonamides____.Sulfathiazole
   Sulfapyridine





Sulfonamide Derivatives:
a. Sulfonylurea hypoglycemics
Carbutamide (Carbutamide)
Tolbutamide (Orinase)
Chlorpropamide (Diabinese)
b. Chlorothiazide diuretics
Chlorothiazide (Diuril)
Hydrochlorothiazide (Hydrodiuril) (Esidrex) (Oretic)
Benzthiazide (NaClex)
Trichlormethiazide (Naqua) (Metahydrin)
Flumethiazide (Ademol)
Hydroflumethiazide (Saluron)
Methyclothiazide (Enduron)
Bendroflumethiazide (Naturetin)
C. Phenothiazines—Chlorpromazine (Thorazine)
Prochlorperazine (Compazine)
Promazine (Sparine)
Mepazine (Pacatal)
Promethazine (Phenergan)

There is some evidence to suggest that sun sensitivity drug reactions may initiate collagen diseases. This emphasizes the importance of avoiding these reactions.

3. Do advise patients known to be sun sensitive to wear a sun screen cream. The most effective one available at present is 15% para-aminobenzoic acid in a simple vehicle. Best proprietary sun screen is Skolex (J. B. Williams Co.) or A-Fil (Texas Phar. Co.).
4. In case of continued sun sensitivity, Aralen, systemically may be worthwhile.

Surgical Treatment of Ventricular Septal Defect: Analysis of 300 Consecutive Surgical Cases—D. A. Cooley, H. E. Garrett, and H. S. Howard Progr Cardiov Dis—Vol. 4:312 (Jan.) 1962

During the 5 year period from January, 1956, to January, 1961, the pump oxygenator was used for open repair in 867 cases of congenital cardiac defects, and 177 patients underwent operation for acquired lesions. Ventricular septal defect was the most frequent congenital cardiac anomaly. The authors review their experience in 300 consecutive cases of ventricular septal defects. Forty deaths occurred in these 300 cases (13.3%). Analyzed according to age groups, the threat to life by corrective surgery was greatest in infants. There were 17 deaths in 44 infants (39%) less than 2 years of age at the time of surgery. The age group from 2 to 14 years included 193 cases with 14 deaths, or a 7.3% surgical mortality. The degree of pulmonary hypertension and pulmonary vascular resistance was proportional to surgical mortality in the defect. Patients with severely elevated pulmonary vascular resistance and a right-to-left shunt had a high surgical mortality (71.4%) and most survivors were not improved sufficiently to justify the risk of surgery. Operation in patients with low pulmonary vascular resistance and left-to-right shunt was associated with minimal risk and excellent functional recovery.

Delayed correction of type III imperforate anus in the male child. R. R. Bradham. (Charleston) Ann Surg 154:973, 1961.

Specific problems related to the management of the male child born with type III imperforate anus and who has had a colostomy at birth are discussed. These include the placement of the colostomy, timing of the definitive operation and diagnostic procedures. Cystograms, urethrograms, and radiography of the terminal bowel are done to clarify the abnormal anatomy. Coexistant congenital anomalies are evaluated. Definitive operation is performed between the ages of 12 and 18 months, provided a maximal state of health has been attained. The abdominoperineal operation is done unless the blind end of the bowel and fistula are extremely low. Careful follow up and parent instruction in care is mandatory. Three cases treated at the Medical College Hospital are presented.

R. R. Bradham

Ipecac Poisoning—T. Bates and E. Grunwaldt Amer J Dis Child—Vol 103:169 (Feb.) 1962

Two children, 4 years and 34 months old, were respectively and inadvertently given 10 cc. and 5 cc. of fluid extract of ipecac as an emetic after accidental ingestion of aspirin. Both children developed convulsions, one progressing to coma. Both had nausea, vomiting, and diarrhea which persisted for many days; there was an initial leukocytosis of over 60,000 wbc., with an increase in both the granulocyte and lymphocyte series and a rapid fall, progressing in the 4-year-old, to death on the seventh day, maturation arrest of the granulocytic series. The symptoms, signs, and pathological findings of poisoning with ipecac alkaloids are reviewed. Fluid extract of ipecac is 14 times as strong as syrup of ipecac; and its inadvertent use as an emetic may be followed by grave toxicity and death.

President's Page



The Annual State Meeting was one of the best that I've attended. The scientific material was interesting and instructive. The business of the Association was taken care of by Council and the House of Delegates in good fashion. I believe each of us should accept his responsibility for his part in the Association's purpose and business. It is the duty of each doctor to urge the citizenship of the state to vote for representatives who will support anti-socialistic legislation. Have you checked with your United States Senator and Congressman recently? The bells may be tolling for our profession.

Dr. Waring and I attended a session of the South Carolina Associated Press News Council at Hilton Head on May 19, 1962. They are very interested in publishing the medical news of South Carolina. I think our press relations are good but can be made better. If newspaper men and medical societies or hospital staffs would work up a medical news code, many areas could get improved coverage. Such a news code would govern the details of the physician-press relationship. Charleston has a code which would be an excellent guide for other societies; and other material is available for interested groups.

If any of you have suggestions for improving the Medical Association's usefulness to the profession and its service to the health of the public, please let me know.

Toolie

P.S.

Take time to learn about the Kerr Mills Bill and how it operates. Write your congressmen and encourage your patients to write, especially those patients over 65 years of age.

Editorials

Medical Schools

For a long time it has been recognized that the production of physicians is not keeping pace with the burgeoning population. This fact has been discussed often and various factors in its origin have been offered. Competing attraction from other scientific fields has been one of the main obstacles to the continued call to the more arduous and less gainful career of the true physician. Applications to medical schools have declined, and the quality of the candidates has also become less desirable. Many applicants are turned away, and even though many of them may not be of top quality it would seem that there should be an opportunity for them to pursue their chosen education. More medical schools should be established to take up the slack.

Emphasis on the problem has come closer to South Carolina with the proposal from several communities that medical schools be established in their areas. The strongest voice has come out of Columbia, one not much weaker from Greenville, and rumblings somewhat less vocal and serious from Greenwood and Florence. It is to be hoped that these proposals, even though they are not very concrete, are based on serious consideration of the needs and abilities of the state in medical education, and not simply on local pride and desire to have a medical school in the midst of interested communities.

A medical school is a very costly thing. Competent faculties are hard to find. The existing school in South Carolina is not always happy with the amount of financial support which it gets from the people of the state. There is a very pertinent question whether the state can afford another school or other schools when its already established and expensive operation is not supported at the best level.

One may wonder whether physicians of the areas now talking medical schools are desirous of themselves participating in a teaching program, or would be content with importation of a new and fulltime faculty. The use of the part-time clinician has been greatly reduced in medical schools, including our own, for better or worse, and emphasis is on referral of patients and on research. Assuming the possible development of one or more additional schools, the referral business would have to be much divided, and so presumably would be state support.

The Journal takes no sides. It simply attempts to point out certain considerations in this new effort. The expression which it has seen has been almost entirely in newspapers, and some of it from chambers of commerce. Statements might be more convincing if they had come from county medical societies and the South Carolina Medical Association, both of which have very considerable interest and stake in medical education in South Carolina.

Look Now

At a time when medicine needs every kind voice to maintain its position in the face of the organized campaign of distorted statements and apparently deliberate falsehood by the present administration, *Look* magazine of June 19 has dealt a bitter blow at a most inopportune time.

It carries front cover scarehead type referring to one of its articles, with the eye-catching words

MEDICAL FEE SPLITTING
KNIFE-HAPPY SURGEONS
MERCENARY DOCTORS

The article itself occupies a back place in the magazine, and it is one of those not infrequent outbursts against abuses and dishonesty in medicine. There is no doubt that there are instances of behavior by physicians which cannot be condoned, but why the Park Avenue physician-author chose this time to wash medicine's dirty linen in public is scarcely comprehensible. Certainly *Look* magazine and the writer have done a great disservice to medicine.

It is rather difficult to figure how this kind of exposé accomplishes any possible reform in

medicine. Undoubtedly, it lines the pocket of the physician who chooses to cry abuse in the market place rather than to utilize his energy and conviction to bring about improvements within the structure of medical discipline.

Sobering Note For Summer

Among all the cheerful, tempting and carefree tidings of summer vacations which cross our desk is one sobering notice from the F.B.I.

Crime rises during the summer.

According to established seasonal trends, forcible rape rises approximately 16%. Murder and aggravated assault climb some 12% each. A similar increase is registered in depraved sex attacks on children.

To a large degree this is due to the carelessness of citizens in a holiday mood. Travelers forget their wonted caution and pick up the lonely and deadly hitchhiker. Families anxious to be away leave their homes in such a state as to invite burglars. Yards are littered with newspapers and accumulated mail, and milk bottles clutter the door. Happy vacationers leave their automobiles unlocked. Children, out of school and with time on their hands, wander into secluded spots, or yield to the temptation of something new—a ride in a stranger's car.

J. Edgar Hoover writes: "Parents who fail to warn their children to avoid secluded spots, to refuse rides and reject gifts or enticements from strangers are guilty of gross negligence."

Perhaps a reminder from the family doctor might help.

Thanks To The Auxiliary

"S. C. Congressmen's Mail Mostly Anti-Medicare." This headline appeared over a story in the Charleston News and Courier of June 8. A subhead added the further information "Letter Volume Is Heavy." We feel that the Women's Auxiliary deserves a hearty vote of thanks for the work they have done to make these headlines possible!



Dr. Robert Wilson
President Elect

Dr. Wilson was born in Charleston on May 3, 1905, and attended Princeton University, and graduated in medicine at the Medical College of South Carolina in 1930. He served in hospital appointments at the University Hospital, Baltimore, Maryland, and the Boston City Hospital and has been in practice in Internal Medicine in Charleston since 1933.

Dr. Wilson has been a member of the faculty of the Medical College since that time and is now Clinical Professor of Medicine. He has been certified by the American Board of Internal Medicine (1942) and has been a Fellow of the American College of Physicians since 1938.

Dr. Wilson has served in many official capacities in medical organizations, having been president of the Medical Society of South Carolina (Charleston) for two terms of two years each. He has been secretary of the South Carolina Medical Association since 1953, and has always maintained a very active interest in the affairs of the Association. He is also currently a member of the residency review

committee of the American Medical Association.

Dr. Wilson is an active member of many medical, social, and religious organizations. A former vestryman of St. Michael's Episcopal Church, he holds membership in the St. Andrews Society, South Carolina Society, Kiwanis Club, Carolina Yacht Club and the St. Cecilia Society.



Samuel Eugene Miller, M. D.
Vice President—1962-63

Dr. Miller was born December 31, 1905 in Spartanburg County. He is a graduate of Pauline High School, Pauline, S. C., Furman University (B.A. degree 1928) and the Medical College of South Carolina (M.D. degree 1934). He interned at Roper Hospital, 1934-35, took post graduate courses in chest diseases at Saranac Lake, N. Y. and Bellevue Hospital (1938) and served as staff physician, South Carolina Sanatorium from 1938 to 1941 and from 1945 to 1947.

He saw military service from 1941 to 1945 and was Chief of Medical Service, Regional Hospital, Camp Shelby, Miss. He is now a Colonel in the Medical Corps, U. S. Army, Reserve.

Since 1947 Dr. Miller has been engaged in the general practice of medicine in Georgetown, S. C. He is at present Vice-President of the South Carolina Tuberculosis Association.

Benjamin Neely Miller, M. D.
New Secretary of The Association

Benjamin Neely Miller was born in Smyrna (York County), South Carolina on Dec. 20, 1910, the son of Benjamin Neely Miller, Sr. and Addie Jane Whitesides Miller. After graduating from public school in Hickory Grove, S. C., he attended Duke University and received his M.D. degree from Duke University Medical School in 1931. His medical residency was done at Duke Hospital (1935-37) and he was instructor at the University of Alabama Medical School from 1937 to 1938. Since that time he has been engaged in the private practice of internal medicine in Columbia, S. C.

Dr. Miller is a Fellow and a life member of the American College of Physicians, a Fellow of the American College of Allergists, and the American Academy of Allergy. In 1948 he was certified by the American Board of Internal Medicine. He is a past president of the South Carolina Society of Internal Medicine, the Columbia Medical Society, and the Southeastern Allergy Association. Also in the past he has served as Chief of Staff at the Providence, Baptist and Columbia Hospitals and as medical consultant for the Veterans Administration. At



present he is medical consultant for the South Carolina State Hospital, the State Department of Vocational Rehabilitation, and Shaw Air Force Base Hospital. He is a member of the South Carolina Medical Association and the American Medical Association.

Active in community, educational and civic affairs, Dr. Miller is a member of the Board of Trustees of Duke University, and immediate past president of the Duke Alumni Association and the Duke Medical Alumni Association. As a member of the Eastminster Presbyterian Church, he is an elder and chairman of the Long-Range Planning Committee. He is a member of the Kiwanis Club and the Forest Lake Country Club, Chairman of the Medical Advisory Committee of the Community Services, the Medical Advisory Committee of the United Health and Medical Research Foundation of South Carolina, and a member of the Board of Directors of the Professional Equity Fund. He is also vice-president and medical director of the Equity Life and Annuity Insurance Co. and a participating member of the Alumni Association of the Medical College of South Carolina.

SCALPEL

A group of South Carolina Physicians from various sections of the State had an organizational meeting at the Wade Hampton Hotel, Thursday, May 17, 1962 to form a political action committee. The name chosen for the group was SCALPEL, (a surgeons knife) the initials of SOUTH CAROLINA ALLIANCE (FOR) LIBERTY, POLITICAL EDUCATION AND LIFE.

SCALPEL is a voluntary, non-profit, unincorporated group whose membership consists of physicians, their wives, immediate family, and others. The newly created group's Board of Directors are: Harrison L. Peeples, M. D., Estill; Ripon W. LaRoche, M. D., Camden; Paul R. Massengill, M. D., Greenwood; Marion Davis, M. D., Manning, W. A. Black, M. D., Beaufort; Pierre F. Laborde, Jr., M. D., Columbia; Mrs. P. G. Hepfer, Columbia; Howard Poston, M. D., Kingstree; L. L. Brown, M. D., Charleston; Thomas Parker, M. D., Greenville.

The group was formed to meet an urgent need—the need of providing the medical profession with an opportunity to assume a more effective and a more active role in public affairs. SCALPEL's dual role is (a) to help its members understand political issues; and (b) to organize them as an effective political action group.

SCALPEL is not affiliated with either major political party. It will not be bound by Democratic or Republican party labels. The program and platform of the individual candidate will determine whom the group supports—*not* the candidate's party affiliation.

This activity is considered to be long range and permanent in nature. Many physicians and others throughout this state have indicated their desire to expand their knowledge of government and their activities in the field of political action. SCALPEL's members are profoundly interested in making this organization an effective, year-in-and year-out operation. Experience has demonstrated beyond argument that one-shot, one-issue membership programs for political education and action accomplish little; and that political effectiveness depends upon a knowledge by the individual and group of current issues, and continuity of their participation in political affairs.

The purposes of SCALPEL are: (1) To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs. (2) To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records of officeholders and candidates for elective office. (3) To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities. (4) To do any and all honorable things necessary or desirable for the attainment of the purposes stated above. (5) To coordinate its efforts with the efforts of those individuals and groups—medical and non-medical—who are actively engaged in programs designed to obtain better government.

SCALPEL members should remain active in the political party of their choice. SCALPEL simply furnishes the means whereby they can increase their political effectiveness substantially through combined effort.

SCALPEL will function independently of all medical organizations and societies—national, state, and local. However, the group will cooperate, whenever possible, with the American Medical Political Action Committee in jointly soliciting membership and on matters of mutual concern.

The Committee's program will be supported by voluntary membership and contribution by interested friends.

Dr. Harrison L. Peeples, State Chairman,

quotes—"If you are too busy to take an interest in government and feel that getting mixed up in politics is beneath your dignity, then at least take time for one thing—teach your children to count in rubles; they will need it with the inheritance you are leaving them."

Detailed information of organization will be mailed to all doctors of the State in the near future. Inquiries should be directed to: Chairman—Harrison L. Peeples, M. D., Estill, S. C. or Secretary & Treasurer—Thomas Parker, M. D., Greenville, S. C.



Charleston's Crippled Children's Rehabilitation Center

The picture above shows the artist's concept of the new Crippled Children Rehabilitation Center which is about to be constructed in Charleston. This Center is the culmination of many years work and planning by the Charleston Chapter of the Crippled Children Society and by the S. C. Society for Crippled Children and Adults, Inc. and the National Society. It is the outgrowth of a less ambitious project which has been operated for some time as the Easter Seal Orthopedic School in Charleston, and will function under a medical director and assistants in the special handling of cerebral palsy and other crippling conditions.

The Charleston Sertoma Club has been the great benefactor of this activity. Now with funds donated by the Club, other funds obtained under the Hill-Burton Act, donations by the Saul Alexander Foundation of Charleston and the combined efforts and generosity of many Charleston firms who have supplied necessary fill to make solid ground of the lot, an adequate physical structure and a broad program for the care of the crippled child will be provided. Assistance will be given by the Charleston school system through the provision of teachers in the fields of speech therapy, physical education, psychological service, etc. The State Department of Public Welfare will also furnish part time personnel, and the State Department of Vocational Rehabilitation will participate. Services will also be available from the State Board of Health.

This then becomes a complete operation and one which will furnish valuable service and will also be available for such teaching purposes as may be requested of it by the Medical College. Some extension beyond the number of the patients of the present Orthopedic School is anticipated, but this is not a project which is intended to include a very large number of children, but rather an effort to give all required services to a moderate number of from 50 to 100.

There seems to exist some uncertainty in the minds of many people who confuse the activities of the Crippled Children Society (or more officially the South Carolina Society for Crippled Children and Adults, Inc.—the "Easter Seal Society") and the Crippled Children's Division of the State Board of Health. The Society is a voluntary agency which is affiliated with state and national activities and has promoted an effective program in South Carolina for many years. The program has been centered lately on cerebral palsy, but many other conditions are also included. Services include clinics, therapy, recreation, braces and appliances, special education programs, and a variety of other worth while special activities. The Society also underwrites the cost of a Chair of Special Education at the University of South Carolina in Teacher-Training for special classes of handicapped children. It receives its support from the Easter Seal Campaign and other special gifts.

The extensive program of the Crippled Children's Division of the State Board of Health parallels that of the Crippled Children Society

to some extent but is a more widespread and extensive service. Its interest is in any form of crippling conditions which come within its specified categories, such as diseases of bones and joints, certain congenital malformations, some neuro-muscular diseases, rheumatic fever, epilepsy, congenital heart conditions, burns and other conditions. It provides a large number of clinics conducted by orthopedists and pediatricians in conjunction, offers hospitalization, convalescent home care, prosthetic appliances, and a summer orthopedic camp program. Its support is through state and federal funds.

These two programs work harmoniously and are interrelated in many cases. There is ample need for both of them and no conflict occurs.

Minutes of Council Meeting
Myrtle Beach, S. C., May 8, 1962

This first meeting of Council in connection with the Annual Session of the Association was called to order at 9 a. m., May 8, 1962 by the Chairman, Dr. John Brewer, at the Ocean Forest Hotel, Myrtle Beach, S. C. Members present included Drs. Fleming, Scurry, Eaddy, Johnson, Booker, Wyatt, Gressette, Thomas, Siegling, Cain, Burnside, Waring, Wilson, Stokes, Evatt and Mr. M. L. Meadors.

The minutes of the meetings of October 18, 1961 and February 7, 1962 were read and approved.

As the first order of business Dr. Brewer suggested that one member of Council be in a position to appear before the House of Delegates and speak regarding the public relations program. Dr. Cain suggested that the Chairman, Dr. J. I. Waring, was the individual most suited for this task, and Dr. Gressette moved that the House of Delegates be asked to approve the present public relations program, under the guidance of Dr. J. I. Waring, Chairman, at a cost not to exceed $5,500.00. After considerable general discussion this motion was approved.

Dr. J. H. Stokes presented his report as Treasurer of the Association, which was received as information with the thanks of Council.

Council then went into executive session for the discussion of certain matters, during which no action was taken to be reported on resumption of regular session.

As Chairman of the Advisory Committee to the Women's Auxiliary, Dr. R. W. Hanckel reported that he had been asked about the advisability of the formation of a political action committee by the Auxiliary. It was the opinion of Council that there was no reason to form such a Committee, as the Association already had a Legislative Committee to deal with these matters.

On proper motion Council approved the sponsorship of the A.A.P.S. Essay Contest for the next year, at the same expense.

The letter of Dr. J. P. Cain to all members of the Association regarding political matters was noted with the approval of Council.

On motion of Dr. Wyatt, Dr. Paul Sasser of Conway, S. C. was elected to Honorary Membership in the Association because of his retirement from practice, other requirements having been fully met.

Dr. Wyatt presented the request of the Arthritis and Rheumatism Foundation for endorsement by the Association. After considerable discussion as to policy and procedures, it was decided not to recommend endorsement at this time. Dr. J. P. Cain then moved that Council instruct the President of the Association to appoint a permanent special committee whose function would be to study the credentials of all voluntary health organizations seeking the endorsement of the Association, and to make recommendations to the House of Delegates regarding such endorsements; this committee would also consider the advisability of the establishment of medical advisory committees to all such organizations having and seeking the endorsement of the Association. This motion was passed.

Dr. Wyatt then presented certain communications which were received as information. He then requested the approval of Council to send telegrams to all candidates for the office of United States Senator asking for a statement of their stand on the King-Anderson Bill for the information of the Association. This request was approved.

Council next considered the matter of the establishment of a committee on education and after a considerable discussion it was moved by the Secretary that the Chairman of Council be directed to appoint a Committee of Council to consider the formation, function, duties, and set-up of a permanent advisory committee on education, to work with the administration of the Medical College of S. C. in an advisory capacity as to the ways in which the Association might be of help in matters regarding under-graduate and post-graduate medical education. This committee of council was also to consider the advisability of the formation of a committee on liaison with other state agencies having medical advisory committees. This motion was passed.

It was noted with interest and enthusiasm that a member of the Association, Dr. Frank Owens was a candidate for the United States Congress in the Second District.

As President of the South Carolina Medical Service Plan, Dr. J. A. Siegling then presented his report and with unusual clarity gave Council the details of the proposed Medical Care Plan for the Aged. Dr. Siegling's report was enthusiastically endorsed by Council, as well as approval of the nominees suggested for the Board of Directors of the South Carolina Medical Care Plan.

Council then adjourned at 12:50 p. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

Minutes of Council Meeting
Myrtle Beach, S. C., May 9, 1962

Council reconvened at 8 a. m. on May 9, 1962 at the Ocean Forest Hotel. The meeting was called to order by the Chairman, Dr. John Brewer. Members present included Drs. Fleming, Scurry, Eaddy, Johnson, Booker, Stokes, Wyatt, Gressette, Waring, Wilson, Evatt, Perry and Mr. M. L. Meadors.

Mr. Joe D. Miller, Executive Director of the American Medical Political Action Committee, spoke on the recent formation of this committee and its proposals for activity. Dr. Gressette suggested that Mr. Miller be allowed to speak directly to the House of Delegates and Dr. George Johnson moved that Council approve the formation of a South Carolina Political Action Committee. This motion was carried.

Dr. Wyatt announced that he had received a telegram from Mr. Workman in which he stated that he was opposed to the passage of the King-Anderson Law.

Dr. Gressette noted that he was scheduled to attend a meeting of the South Carolina Press Association during May 1962, and this announcement was followed by a discussion as to how more satisfactory relations could be made with the press.

Mr. M. L. Meadors, reporting for Dr. J. P. Cain, informed Council on the present status of the health insurance policy, noting that 182 applications had been received thus far, he stated that when 300 applications were at hand, no examination or inquiry would be needed, but with the number only at 182 the committee asked the approval of Council for an inquiry as to health information, which was granted by Council.

Mrs. John P. Cuttino, President of the Women's Auxiliary, Mrs. Taylor, Treasurer, and Mrs. Wilkins, the President-Elect, appeared before Council and gave their report. It was noted that the Woman's Auxiliary was having financial difficulties, and the increase of payment to this organization from 50¢ to $1.00 a member was approved.

The Council then recommended the nomination of Dr. J. H. Stokes to be presented to the House of Delegates for election as Treasurer of the Association.

The following nominations were approved by Council for presentation to the House of Delegates as nominations for the Mediation Committee.

Third District—Dr. Robert Clark of Abbeville and Dr. George McFadden of Newberry.

Sixth District—Dr. Harry Allen of Florence and Dr. Sam Cantey of Marion.

Ninth District—Dr. Charles Hanna of Spartanburg and Dr. Francis Owens of Union.

Council then adjourned at 9:15 a. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

Minutes of Council Meeting
South Carolina Medical Association
Thursday, May 10, 1962

Dr. John M. Brewer, Chairman of Council, called the meeting to order.

Dr. Charles N. Wyatt, President, reported on a letter from Mr. W. D. Workman, Republican candidate for the United States Senate. According to the communication, Mr. Workman is opposed to the King-Anderson type of legislation. Dr. Wyatt reported further that he had had a verbal message from Mr. Hollings that he also opposed the King-Anderson type of social security - medical care program.

The subject of a two year medical school connected with the University of South Carolina was now discussed by the Council as a whole. As announced, there will be a meeting referable to this matter in Columbia under the sponsorship of the Chamber of Commerce on Wednesday, May 16, at 4:00 p. m. It was proposed that Doctors Wyatt, Burnside, Gressette, and others attend this meeting representing the Council.

Dr. J. I. Waring, Editor of the Journal, reported on his budget request for fifty-five hundred dollars ($5,500.00) for public relations' promotion. This had been recommended by Council anl passed on by the House of Delegates. Dr. Waring will have the responsibility of this function and will report to Council.

Dr. Waring reported that Dr. Vince Moseley in Charleston and Dr. E. W. Masters in Columbia have asked permission to conduct a self-treatment group for arthritics (under the sponsorship of the American Arthritic Society). It is understood that this is to be more of a group psychology approach.

It was reported that Dr. Harrison Peeples has been elected State Chairman of the American Medical Political Action Committee (A.M.P.A.C.). An organizational effort is to be made statewide. This effort is independent of the state organization, and this is recorded as information.

It was ruled that the Chairman of Council and the Secretary may okay minutes prior to submitting to Dr. Waring for publication in the Journal (publication in part).

At this time the organization of Council and election of its officers was conducted. Dr. A. F. Burnside, Vice-Chairman, presided. Dr. John P. Booker nominated Dr. John M. Brewer to succeed himself. The election was unanimous. With Dr. Brewer presiding, Dr. Wyatt nominated Dr. A. F. Burnside to succeed himself as Vice-Chairman of Council. He was elected unanimously. Dr. Wyatt nominated Dr. William L. Perry as Clerk of Council. His election was unanimous.

With the completion of the election of officers and re-organization, Council adjourned the meeting.

Respectfully submitted,
Ben N. Miller, M. D.
Secretary

News

Interstate Offers Varied Program For GPs

The 47th annual Scientific Assembly of Interstate Postgraduate Medical Association, to be held at the Palmer House, Chicago, October 1-4, offers 20½ hours of varied teaching (and A.A.G.P. Category II credit) for a registration fee of $10. The program is especially suited to the needs of generalists, as all lectures, panels and clinics are closely related to medical problems familiar to the physician who does not devote his time to a single specialty. Panels on "Arthritis", "Diabetes", "Tranquilizers and Energizers", the "Medical and Surgical Treatment of Duodenal Ulcers", and "Newer Treatment of Hypertension" are important parts of the three and one-half day program.

Those interested in full details of the program are urged to write for a brochure, by addressing a postal to N. A. Hill,M. D., Secretary, Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wisconsin.

S. C. High in Self-Help Medical Plans

South Carolina is among the top five states in the USA in the number of people receiving the Medical Self-Help Course. The course, giving basic information a person needs in order to preserve life and health in time of natural or manmade national disaster, is being sponsored by county health departments in many places in the state. The Orangeburg Health Center and the Fairfield County Health Department have recently started such courses and Florence county is one of the top counties in the nation in the program.

New Health Centers For Florence County

Contracts have been awarded by the Florence County Governing Board for four health centers to cost $106,000. These centers will be located in Olanta, Pamplico, Johnsonville and Timmonsville.

Speaker's Symposia on Aged Care

A Speaker's Symposium was held in Charleston on June 9 on the current proposed legislation for the care of the aged. This symposium, promoted jointly by the S.C.M.A. and the A.M.A. was repeated in Columbia on June 10. Those in attendance consisted of representatives of various medical societies, auxiliaries, civic clubs and other interested individuals.

Mr. Darrell Coover and Mr. Richard Nelson of the A.M.A. presented up-to-date information on the status of the King-Anderson Bill, and Mr. Coover gave interesting hints on the technique of presenting this information to the public. The attendance was not as large as might have been desired, including some 30 persons in Charleston and 39 persons in Columbia, despite the fact that the meetings were well publicized and were most timely. Apparently nothing short of a bomb is going to bring out a large participation in this type of meeting and others similar to it, all of which are so vital to the preservation of the present status of medicine. Nevertheless it is felt that the meetings were useful and stimulated activity which would not have developed otherwise.

Doctors Speak

Dr. Clay W. Evatt, Charleston, addressed the Carolina Medical Industrial Association at Raleigh, N. C. on May 6.

Dr. J. H. Gressette, President of the Association, spoke to a meeting of the South Carolina Associated Press News Council at Hilton Head on May 19. Dr. J. I. Waring added some remarks to the discussion of the talk. A cordial relation seems to exist between the profession and the press in South Carolina.

Tennessee Valley Medical Assembly

The Tennessee Valley Medical Assembly, sponsored by the Chattanooga and Hamilton County Medical Society, Inc., will hold its 10th Annual Assembly at Read House, Chattanooga, Tenn., September 24, 25, 1962. AAGP members will be granted 11 hours category one credit for two day's attendance.

Heavy demand for hotel accommodations makes it imperative that physicians who plan to attend the Assembly write without delay for reservations to: Chattanooga Convention & Visitors Bureau, 819 Broad St., Chattanooga, Tenn. Registration fee is $15, and should be enclosed with the reservation request; the check made payable to Tennessee Valley Medical Assembly. Banquet tickets are $7.50 each and can be purchased by mail or at the Registration Desk.

American Academy of Pediatrics

The American Academy of Pediatrics recently admitted 303 new members, bringing their total number of fellows to 7,542. Among those granted fellowship in the Academy were five South Carolina doctors: W. B. Ardrey, III, Rock Hill; Griggs C. Dickson, Hartsville; Eleas Frank Lawandales, Charleston; David C. McLean, Florence; and Samuel Roscoe Moorhead, Jr., Anderson.

Grants for Research on Alcoholism

The Scientific Advisory Council to the Licensed Beverage Industries, Inc. is now inviting applications for Grants-in-Aid to further the study of alcohol and alcoholic beverages. Since the grant program was initiated two years ago, the Council has approved some forty grants totalling nearly $200,000. Further information may be obtained from: Scientific Advisory Council to the Licensed Beverage Industries, Inc., 155 East 44th St., New York 17, N. Y.

North Carolina Postgraduate Medical Program

"Marriage Counselling in Medical Practice"
Friday and Saturday, October 19 and 20
Clinic Auditorium, U.N.C. School of Medicine,
Chapel Hill, N. C.
Sponsored by the U.N.C. School of Medicine,
the American Association of Marriage Counsellors and
the N. C. Neuropsychiatric Association
Tuition: $15.00 (includes social hour and dinner,
Friday, October 19)

A block of tickets to the North Carolina-South Carolina game will be reserved *on June 15* until September 1 for those attending. *After June 15*, send checks ($4.50 plus 25¢ for mailing) to UNC Athletic Ticket Office, Box 109, Chapel Hill, mentioning this course. Accommodations will be limited. The Carolina Inn and motels will give preference to those reserving rooms for Thursday, Friday and Saturday nights, otherwise rooms must be vacated by 3:00 p. m. Friday. Please make your reservations early.

Dr. Peeples Re-Elected State Health Officer

Dr. G. S. T. Peeples, State Health Officer, has been re-elected to a five-year term.

The announcement was made by Dr. W. R. Wallace, Chairman of the Executive Committee of the State Board of Health, after the May meeting of the Committee in Myrtle Beach.

Dr. Peeples has served as South Carolina's fourth State Health Officer since 1954 when he was recommended by the S. C. Medical Association and the Executive Committee and appointed by then—Governor James F. Byrnes to succeed the late Dr. Ben F. Wyman.

Dr. Sheriff Is President of Association of MCH and CC Directors

Dr. Hilla Sheriff, Director of the Maternal and Child Health Division, in June attended the biennial meeting of the National Association of MCH and CC Directors. Dr. Sheriff is president of this organization. The meeting was in Denver, Colorado.

The Association has been very active during the year in trying to raise the authorization of funds for both the maternal and child health and crippled children programs.

Dr. A. R. Johnston Elected

Dr. A. R. Johnston of St. George was elected by acclamation president of the Associations of Physicians and Surgeons of the Southern Railway System at a meeting in Atlanta. Included in the association's membership are physicians and surgeons from 15 states.

Dr. Johnston is county health officer, a member of the board of trustees of School District Number 1, and is active in church and civic affairs.



Mrs. McMurry Wilkins New Auxiliary President

Mrs. Ruth Wilkins, new president of the Woman's Auxiliary to the South Carolina Medical Association, is the wife of Greenville internist McMurry Wilkins. A graduate of Furman University and the busy mother of three children. Mrs. Wilkins somehow finds time for many civic and church activities and for her hobbies, reading and bridge. She teaches Sunday School, is a member of the Woman's Society of Christian Service of the Buncombe Street Methodist Church, a member of the Board of Stewards of this church and a Circle Leader. Besides her church work, Mrs. Wilkins is an officer in P.T.A., a member of the Sweetbrier Garden Club and a member of the Greenville Woman's Club.

List of Promotions Medical College of South Carolina

PATHOLOGY

Dr. Edward Earl McKee: from Associate Professor to Professor and Acting Chairman of the Department.

Dr. McKenzie Parker Moore: from Assistant Professor to Associate Professor.

Dr. Forde Anderson McIver: from Assistant Professor to Associate Professor.

MEDICINE

Dr. Maria Gordon Buse: from Associate in Chemistry to Assistant Professor of Research Medicine.

Dr. Louis Preston Jervey, Jr.: from Associate to Assistant Professor of Medicine (Preventive Medicine)

Course in Laryngology and Bronchoesophagology

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from September 24 through October 6, 1962, under the direction of Paul H. Holinger, M. D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants please write: Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

BUSINESS SPEAKS

The Greater Charleston Chamber of Commerce

TO WHOM IT MAY CONCERN:

Attached is a Resolution passed by the Board of Directors of the Greater Charleston Chamber of Commerce on May 22, 1962. Those familiar with the financial situation in South Carolina, especially pertaining to educational institutions at all levels, realize that it is not practical to have an additional burden placed upon the taxpayers for a second state supported medical college. Medical education in South Carolina can best be served by using available funds to improve and expand the existing facilities of the present Medical College of South Carolina.

At the same meeting the Board of Directors went on record as opposing the health-care Bill (HR 4222-proposed by the Administration. Consensus of the Board is that the present Kerr-Mills Act provides the basic health services necessary for the medically indigent. There is great danger that the so-called "Medicare" bill, with benefits to be paid through Social Security, will cost a great deal more than the proponents estimate, will endanger the entire Social Security program, and will present a great danger of growing into a full scale plan of Socialized Medicine.

A third action of the Board of Directors was taken in opposition to the bill to establish a 20% withholding tax on dividends and interest. It is felt that passage of this bill will result in an unprecedented amount of paperwork on the part of private enterprise and government alike. Consensus of the Board is that this bill is unnecessary and unjustifiable. The bill (H. R. 10650) has been passed by the House of Representatives and is now under consideration by the Senate Finance Committee.

Very truly yours,
George G. Durst, M. D.
President

Alcoholic Rehabilitation Center

THE SOUTH CAROLINA ALCOHOLIC REHABILITATION BOARD ANNOUNCES THAT APPLICATIONS FOR ADMISSION TO THE PALMETTO CENTER FOR TREATMENT AND REHABILITATION OF ALCOHOLICS WILL BE ACCEPTED BEGINNING JUNE 15, 1962.

The Act of the South Carolina General Assembly which created the Rehabilitation Center provides:

1. Admission to the Center shall be voluntary only.
2. Admission to the Center shall be limited to residents of South Carolina.
3. Patients who are able to pay for their care and treatment shall be required to do so.

The Center can accommodate not more than 30 patients at any given time. Application for admission must be made by letter in advance of the arrival of the patient addressed to Palmetto Center, P. O. Box 1567, Florence, S. C. The application must include a medical history prepared by the patient's physician, and a personal history compiled by the County or local office of the South Carolina Department of Public Welfare. Referral to the Center may be made directly by the patient's physician, by the local office of the South Carolina Department of Public Welfare, by the local or County Public Health Agency, or by the local unit of the Mental Health Commission. The local Mayor's Committee on Alcoholism, or local Council on Alcoholism, if one is available, may also refer patients for treatment. Suitable application forms will be provided to physicians and local Public Welfare and Public Health Offices.

As rapidly as accommodations can be provided and applications processed, acceptable prospective patients will be advised the date upon which they may be admitted to the Center.

No applicant will be admitted to the Center while under the influence of alcohol or addictive drugs.

Patients entering the Center should plan to remain not less than 28 days, or, upon recommendation of the professional staff, for a longer period.

Room and board shall be at the rate of $8.00 per day, in addition to actual cost of drugs and medical services. An entrance deposit of not less than $50.00 will be expected from all patients except those certified as financially unable to pay by the local office of the South Carolina Department of Public Welfare of the county in which the patient resides. These payments shall be required of all patients, and collected in accordance with their ability to pay.

State Board of Medical Examiners of South Carolina Columbia, South Carolina

The State Board of Medical Examiners of South Carolina met on May 9, 1962 at the Ocean Forest Hotel, Myrtle Beach, South Carolina, to interview applicants for medical licensure by endorsement of credentials. Eight physicians were licensed to practice medicine and surgery in the State of South Carolina. They are as follows:

Dr. William B. Helton, Jr. is a '56 graduate of U. Tenn. He was licensed in Tennessee and recently completed a residency in OBG at Greenville. He is now practicing in Greer.

Dr. Walsa R. Henderson, Jr. graduated from Bowman Gray in 1954. He is licensed in North Carolina and plans to move to Spartanburg July 1st. His type of practice is ORTH.

Dr. William H. Lee is a graduate of Emory, class of '54. He is licensed in Ga. and Fla. Dr. Lee has residency training in PED and now practices in Seneca.

Dr. William G. Null graduated from the Med. College of Ala. in '57. He has training in PED. Currently in the USAF at Donaldson AFB, he plans to practice in Greenville.

Dr. Thomas M. Parker is a '54 graduate of the Univ. of Minn. and is licensed in Minn. He took his residency in PATH at Mayo Clinic. He is now teaching at the Medical College of S. C.

Dr. Warren W. Sears graduated from Bowman Gray in 1953. He is licensed in N. C. and Va. Dr. Sears took training in anesthesia and is located in Columbia.

Dr. Warren White is a graduate of the Med. College of Ga., class of '58. Dr. White is licensed in Ga., La., and Ala. where he now does General Practice. He plans to move to Anderson on June 1st.

Dr. Robert E. Bell, Jr. graduated in 1958 from Bowman Gray. He is licensed in Fla. At present in the USAF at McGuire AFB, he plans to begin a residency in psychiatry at the South Carolina State Hospital on July 1st.

Florence Doctors Head Methodist Medical Session

Two Florence physicians will play key roles at the first conference for Methodist medical doctors at Lake Junaluska, N. C. July 12 through July 15.

Dr. Julian Price will be a featured speaker.

Dr. M. R. Mobley of Florence will be the presiding officer as doctors from nine southeastern states focus attention on "The Christian Physician and Contemporary Culture."

Charlestonian Heads Health Association

Dr. Malcolm U. Dantzler of Charleston, director of his county's health department, has been installed as new president of the South Carolina Public Health Association.

Andersonians To Fight Medicare

A committee to combat President Kennedy's "medicare" program has been formed in Anderson, according to Dr. Hugh Croxton, Jr.

Dr. Croxton said the purpose of the organization is to give a "true picture" of the King-Anderson Bill. He said that citizens are not being given all the facts on the bill, but are being given only those which would "sell them" on the Kennedy medical aid program.

The local group has printed some "fact sheets," which will be distributed by women on the citizens' committee.

Dr. Croxton said the committee is made up of a cross-section of local men and women and is working with the "Scalpel" groups.

The doctor said the group is independent of the Anderson County Medical Society and the Dental Society, although members of both groups are included in the committee.

Resolution Adopted by Board of Directors South Carolina State Chamber of Commerce May 17, 1962

H. R. 4222 (KING-ANDERSON BILL)
DESIGNED TO PROVIDE FEDERALLY FINANCED MEDICAL CARE
Under Federal Old Age, Survivors and Disability Insurance System

WHEREAS, Medical science and its allied professions operating under the free enterprise system have given to the people of the Unitd States better medical care, better health and longer life expectancy than are enjoyed by any other people in the world; and

WHEREAS, When other nations have turned to government and its bureaucracy for the advancement of medical science and provision of medical care for their people, instead of progress they have experienced retrogression, excessive cost, and loss of freedom in the relationship between patient and physician; and

WHEREAS, Federal legislation, H. R. 4222 (King-Anderson Bill), now in the hands of the House Ways and Means Committee, proposed federally financed medical care for all citizens over sixty-five years of age who are eligible, under the Social Security system, for Old Age, Survivors and Disability Insurance; and

WHEREAS, According to cost estimates cited by proponents of this Bill, it is obvious that it will not be a self-supporting measure; and

WHEREAS, Present local and State aid programs, and constantly increasing coverage by private insurance programs, demonstrate no proven need for such Federal legislation; and

WHEREAS, Adoption of the proposed Federal legislation would unnecessarily add to the already unmanageable Federal bureaucracy; would provide the machinery for more Federal encroachments on private enterprise, States' and Local governments' rights and responsibilities, and the rights of citizens; and would impose an unrelated additional tax on employing groups to finance such a program, and may further add considerable to the already anticipated deficits under which our Social Security System operates.

THEREFORE, BE IT RESOLVED, By the Board of Directors of the South Carolina State Chamber of Commerce that it shall continue to be the general policy of the Chamber to support and seek to strengthen the advancement of medical science and medical care under the private enterprise system; and to continue opposition to encroachment by the Federal Government and its bureaucracy upon the relationships and responsibilities of citizens in the realm of private medical care, and upon the established responsibilities fulfilled by the State and Local governments.

Dr. T. K. Howard Moving To Durham, N. C.

Dr. T. K. Howard, Woodruff physician closed his office on June 6 and moved his family to Durham, N. C. where he expects to begin serving a two-year residency in Anesthesiology at Duke Hospital July 1.

Columbia Hospital Improvements

The Columbia Hospital is undergoing a major "face lifting" operation, with the addition and alteration of the mechanical and electrical systems.

The changes are part of a long improvement plan.

Included in this phase of the work is the installation of a new heating and cooling system, metal lockers and shelves, wiring for room telephones and television sets, a new kitchen ventilation system, a central oxygen supply system and extension of the vacuum system.

Degrees Granted To 127

The following 127 candidates were awarded diplomas by the Medical College of South Carolina in commencement exercises on June 7.

Doctor of Medicine—David Filmore Adcock, Jr., William Robert Ameen, Hal Cecil Anderson, John Richard Bailey, David Robertson Beckham, Jr., Ronald Dwain Blackston, Guy Smith Blakely, Jane Louise Blakely.

Also, Charles Bailey Bobo, Frank Neville Boensch, Jr., John James Britton, John Pitts Brown, Jr., Charles Grady Cannon, Jr., Ernest Willoughby Carpenter, III, Andrew Robert Cracker, Ina Sylvia Crawley, Richard Hughey Crooks.

Also, William McAlhany Davis, Charles Warren Derrick, Jr., Rex Howland Dillingham, Jr., Doris Anne Edwards, Bobby Flay England, Joseph Franklin Garner, Ronald DeVoe Gaskins, Alan Burnett Glassberg.

Also, Joe Brannon Godfrey, James Franklin Green, John Lewis Guy, James Paget Hentz, Cloud Hardin Hicklin, Carl Julien Hiller, Edgar Olin Horger, III, Roy Edward Hudgens, Jr., Heyward Hudson.

Also, Everett McQuerns Hughes, Archibald Wesley Hursey, Jr., Manly Eskew Hutchinson, Jr., Douglas White Jenkins, Thomas Edward Jenkins, Allen Huggins Johnson, Jr., Ronald Vance Lanford, Robert Gray Mahon, Jr., Charles Raysor May, III.

Also, James Andrews McCord, Roy Maxie McCoy, Robert Louis McDonald, James Eli McFadden, Jr., James Daniel McInnis, William Elliot McLean, Ralph Mollycheck, James Dance Morgan, Margaret Brown Neville.

Also, Charles Jerry Owens, James Thompson Richards, Henry Reed Richbourg, William Gordon Rodgers, Jr., Onex Dara Stevenson, Gerald Leland Summer, Charles Harry Truluck, Jr., William Redd Turner, Jr., George Warren, III.

Also, Garrison Grier Watts, Jr., John Anderson Wells, Jr., Shannon Nelson Weston, Preston Agee Whaley, Barney Levy Williams, Jr., Robert Wilson, Jr. and Ronald Sloan Wise.

Master of Science—David Hale Wayt.

School of Pharmacy—William Marshall Bennett, Jr., Barry Martin Bloom, Demetra Mary Botzis, Rembert Arthur Brewer, Jackie Martin Cantrell, George Marvin Edwards, Dennis Lee Hart, Sewell Irby Kahn, William Young Kline, Harold Edwin Koslow.

Also, Marvin Bernard Kramer, Tommy Joe Land, John Henry Oliver, Jr., John Thomas Perry, Matthew Charles Shaw, John Reese Sheppard, Herman Tuchman, Milton Edwin Wilson, Jr.

School of Nursing—Byrtie Marteen Altman, Rachel Mae Ball, Patricia Ann Benton, Bonnie Jean Bloom, Helen Marie Bohlen, Judith Elaine Bolin, Catherine Wyman Brailsford, Cynthia Louise Brant, Janell Gaye Chryst, Sylvia Jane Cox, Sara Agnes Currence, Linda Kyle Eagerton, Sarah Elizabeth Ferguson, Linda Ann Maloch Fowler, Jeannine Mary Gaulin, Minnie Ann Hayes, Linda Louise Hornaday, Gloria Jean Altman Infinger, Martha Sue Jones, Gloria Ann Kennedy.

Also, Mary Virginia King, Sandra Ann Luckey King, Evelyn Mae Lawton, Charlotte Anne Lesemann, Linda Ellarine Damon Manning, Martha Ann Martin, Martha Virginia McKnight, Miriam Lee McMillian, Anna Margaret O'Bryan, Vivian Laverne Hill Owens, Ruby Jean Price, Patricia Dianne Rentz, Jerilyn Margaret Roof, Rosemary Sellers, Barbara Florene Semken, Mary Ann Smith, Carole Faye Bantz Taylor, Mary Rochelle Walton, Geraldine McInnis Weaver, Gail Whitfield.

Self Memorial Scientific Seminar

The annual Self Memorial Scientific Seminar will be held on Wednesday, August 15th, in the Self Memorial Hospital at Greenwood, South Carolina. The program this year will consist of the following speakers and their titles:

Dr. Robert P. Kelly, Department of Surgery, Emory University School of Medicine. "Acute Osteomylitis"

Dr. Robert C. Schlant, Department of Medicine, Emory University School of Medicine. "Indications for and Limitations of Cardiac Catherization"

Dr. J. Richard Amerson, Department of Surgery, Emory University School of Medicine.
"Abdominal Trauma"

Dr. Wm. C. Waters, III, Department of Medicine, Emory University School of Medicine.
"The Detection of Reversible Hypertension"

Dr. Harry M. Bohannan, Department of Periodontics and Endodontics, University of Kentucky, Louisville, Kentucky.
"Periodontics, New Horizons in Oral Health Care"

Dr. Eugene R. Duggan, Department of Obstetrics and Gynecology, University of Rochester, School of Medicine, Rochester, N. Y.
"Indication for Hysterectomy"

The physicians, surgeons and dentists of South Carolina and adjacent areas are invited to this meeting.

Patricia A. Carter, M. D., Louis E. Nesmith, M. D. announce the association of Carium Joseph, M. D. Practice limited to Obstetrics and Gynecology. Offices: 224 Calhoun Street and Saint Andrew's Center, Charleston.

Regional Education Board

South Carolina's 1962 General Assembly, with the guidance of its permanent committee on mental health and mental institutions, took major action in this field during its recently-adjourned session including authority for a new facility for mentally retarded children.

The lawmakers authorized an expenditure of $500,000 for the center which is expected to be located in the Charleston area. It will be both a school and rehabilitation center.

Another major accomplishment was provision for a state salary for school psychologists employed by local school districts. Under the proposal, one such salary is to be paid for each 5,000 pupils enrolled and with an estimated school population of 550,000 this means a total of 110 positions. At present only three school districts in the state have psychologists.

South Carolina will be one of only a few states to make such provision and the legislation had the enthusiastic support of the state associations for retarded children, mental health and the crippled children's society.

State aid for the excess cost of educating trainable mentally retarded and physically handicapped children in special classes also was provided by an appropriation of $25,000. School districts may claim 70 per cent of this extra cost up to a maximum of $150 per child enrolled.

Pineland, a state training school and hospital for Negro retarded children, was given an increase of $57,000 in its operating budget with almost half of the amount earmarked for occupational training.

Whitten Village, the center for retarded white children, received an increase of over $400,000 which will be used for the construction of two additional dormitories.

An increase of $100,000 in state funds for the agency of Vocational Rehabilitation was granted for undertaking a program of rehabilitation for retarded children who are leaving special education classes at the age of 16.

Over $40,000 was appropriated as the state's share of the yearly cost of operating two new mental health centers under the 1961 Community Mental Health Act.

The South Carolina Mental Health Commission received funds for the employment of an assistant to its research consultant and salaries were authorized for an additional clinical psychologist at the Greenville Mental Health Clinic and for an additional psychiatric social worker at the Rock Hill Mental Health Center.

The South Carolina State Hospital received a total increase of about $720,000 of which $5,000 is earmarked for architectural plans for a chapel and $150,000 for additional employees. Legislation also was enacted extending the limits of the borrowing power of the State Hospital and Pineland. The borrowed funds are to be repaid from fees collected from patients able to pay for their care.

South Carolina became one of the first states in the nation to have a state education program for aphasic children when $70,000 was allocated to the state School for the Deaf and the Blind to launch the project.

And, the Legislature appropriated $155,000 for operation of a newly-constructed alcoholic rehabilitation center in Florence which is to be opened this year. Included will be an adult education program. The Center is to serve 30 patients at one time with the treatment program designed to last a maximum of 30 days.

The Legislative Committee on Mental Health and Mental Institutions was given funds to employ a full time research consultant, John Zuidema, an experienced specialist in mental retardation and mental health.

One major recommendation of the committee which did not pass concerned an appropriation to provide diagnosis and treatment for the emotionally disturbed children at John de la Howe School in McCormick. The school serves 240 children who require care and education outside their homes. The committee expects to introduce similar legislation for the 1963 Legislature.

Practices Available

Opportunities to assume established general practices in Summerville, S. C. and Bethune, S. C. are available. Anyone interested should contact Dr. William R. Wyly, Pine St., Summerville, S. C. or Dr. Roy Ackerman, Bethune, S. C.

Calhoun Falls also offers an opportunity for general practice and anyone interested is requested to write Mr. J. H. Fisher, State Bank and Trust Company, Calhoun Falls, S. C.

Public Relations

Are You A Member of SCALPEL?

SCALPEL, South Carolina Alliance for Liberty, Political Education and Life, was organized in May under the chairmanship of Dr. H. L. Peeples, Estill, S. C. SCALPEL is affiliated with the national organization, AMPAC, American Medical Political Action Committee. Its primary function is to encourage doctors and their families to take an active part in public affairs. The program is designed to help members understand political issues and to work as an effective political action group. Activities are independent of party affiliations and all medical organizations. Funds from membership dues will be used to support candidates selected on the basis of sound political appraisals. A ten-member board of directors will steer the activities of SCALPEL. Directors are Dr. Peeples, chairman; Dr. Thomas Parker, Greenville, secretary-treasurer; Drs. Ripon W. Laroche, Camden; Paul R. Massengill, Greenwood; Thomas M. Davis, Manning; Wescoat A. Black, Beaufort; Pierre F. Laborde, Jr., Columbia; Howard A. Poston, Jr., Kingstree and Laurie L. Brown, Charleston; also Mrs. J. P. Hepfer, Columbia, representing the Auxiliary to the S. C. Medical Association. If you would like to become a member get in touch with the director in your area.

Spartanburg Sponsors Outstanding Ad Series:

The ad reproduced below is one in a series of six sponsored by the Spartanburg County Medical Society. The ads are prepared and made available by the American Medical Association. These ads, which supply a real service to the community, provide a means of medical advertising which is both forceful and in good taste. It is further suggested that campaigns of this nature may be coordinated successfully with Welcome Wagon operations. Hostesses might be supplied with reprints of the ad, or similar information in a simple, inexpensive leaflet. Other societies wishing to sponsor a similar ad series may write to Public Relations Office, Box 275, Charleston, or to AMA, 535 North Dearborn Ave., Chicago 10, Ill.

YOUR DOCTOR AND YOU

When and How to Choose a Doctor.

Do you think choosing the family doctor deserves as careful consideration as selecting the make of the family car?

The typical car-buyer will price three different makes with half-a-dozen dealers. He'll measure headroom, kick tires . . . gather opinions from his friends . . . and wrestle with the problem for weeks.

How does the same man choose his family doctor? Too often he simply waits till an emergency strikes. The truth is an emergency is the worst time to choose a family doctor. On the other hand, having a family doctor chosen well before you need him, assures you and your family the best medical service.

Your family doctor knows your medical history . . . knows what your special problems are. And this knowledge can be invaluable in treating new ailments that may develop.

Suppose you're
new in town

You'll probably find a bank you like . . . a hairdresser . . . a garageman . . . a grocer. Fine! But while you're at it, choose a family doctor. Choose him with care, because he's the man you'll trust with your health—perhaps even your life.

Here are some tips on how to do it.

*Get a list of family doctors by calling our society at the phone number listed below. And if you're new in the community, the family doctor in your old town may be able to make recommendations.

*Learn more about the doctors on your list by checking the American Medical Directory at the public library. It lists all doctors—tells their age, type of practice, medical education, special training and membership in important medical organizations.

*When you've narrowed down to one or two doctors that seem to meet your requirements, call each of them and make a date to get acquainted. Then have a frank talk about office hours, night calls, fees, the hospitals they're associated with and anything else you want to know.

Choose your family doctor carefully. This is one of the most important decisions you'll ever make.

WRITE THE SPARTANBURG COUNTY MEDICAL SOCIETY
753 North Church Street
or call
The Doctor's Exchange 583-2718



Newspaper Liaison:

Leading papers throughout South Carolina have expressed an earnest desire for more medical news and have indicated a willingness to work closely with the S. C. Medical Association in presenting news of its activities to a broad cross-section of readers. Dr. James Gressette, Orangeburg, president of the association, was a principle speaker at a meeting of key news personnel at Hilton Head Island in May. Dr. J. I. Waring, Charleston, chairman of the association's public relations committee, was a special guest and had an opportunity to exchange ideas with the delegates. It has been suggested that the newspapers work closely with the county societies in their areas. If you have not established a personal contact with your newspaper it is urgently requested that you invite the editor to send a reporter to your next meeting. It would be advantegeous to assign one member to work with the reporter, helping him to gather all the facts he may need. The question of medical ethics came up and some of the delegates indicated that there was too much censorship on the part of the medical profession. This was discussed, and as a further step, a booklet explaining the reason and the need for certain restrictions is being made available to all South Carolina newspapers. As a final suggestion . . . if there is news in your area which would be suitable for a state-wide feature story we would appreciate it if you would get in touch with the association's public relations chairman. As an example of good feature material we cite the mass innoculations for polio which were given in Greenville last year. Another excellent feature subject would be the work of some of the new health centers which have been established in small S. C. communities recently, where no medical facilities had been available previously.



Television:

As we go to press the public relations office is working on tentative plans to produce a half-hour taped program on "Medicine Today." The program will be a strong, positive approach pointing out that medical standards in the United States are the finest in the world. It will show something of the research, medical training and hospital facilities available in South Carolina. And it will point out that physicians, with the help of existing voluntary health insurance plans and "aid to the indigent" programs are providing fine medical care for all ages who are in financial need. The tape will be produced with the help of the production staff of WUSN, TV, Charleston. This station has already offered free time for the program.

FUNDS FOR THE PROGRAM WERE DONATED BY HUGH LANE, PRESIDENT OF THE CITIZENS AND SOUTHERN NATIONAL BANK. THE ASSOCIATION GRATEFULLY ACKNOWLEDGES HIS GENEROUS AND GRACIOUS GESTURE.

It is our plan to prepare the taped program in such a manner that it may be adapted to other areas of the state—wherever television stations with tape facilities are located. As soon as this work is completed notices will be sent to county societies and the public relations office will approach stations in your area asking for time.



Speakers Forum:

With the cooperation of Robert E. Tomlin, Blue-Cross, Blue-Shield public relations field representative, a speaker's forum was presented in Charleston, June 9 and in Columbia, June 10. The program was co-sponsored by the S. C. Medical Association and AMA. Darrell Coover, director of the AMA national speakers bureau, and Richard Nelson, AMA district field representative, directed the one-day sessions. The program included a resume of current medical legislation for medical care of the aged, a discussion of the operation and purpose of bureaus, techniques of effective speaking, a panel discussion and speakers clinics. The sessions were open to the public and special invitations were sent to principle civic organizations. New speakers kits were made available to those attending. If you were not able to attend the forums and would like to have one of the new kits please write the public relations office, Box 275, Charleston—or AMA, Chicago.

Closer Liaison:

For some time the public relations committee has realized a need for closer liaison with individual county societies. We are eager to know your problems and to help find practical solutions to these problems. A means of establishing this liaison is now available. ROBERT TOMLIN, Blue Cross field representative, will be traveling throughout South Carolina on a regular schedule. Mr. Tomlin has volunteered to coordinate his activities with those of the public relations program. We feel that this merger will contribute much to the strength of the state-wide public relations program.



Trade Publications:

A new media for explanations of the King-Anderson Bill and the Kerr-Mills law is being used throughout the state. Three company publications . . . Palmetto State Life Insurance Co., Columbia; Liberty Life Insurance Co., Greenville and South Carolina Electric & Gas Company, Columbia and Charleston, carried ads explaining the essential differences in the two programs of Health care for the aged. Two additional publications, of Joanna Cotton Mills, Joanna, and Union Bleachery, Greenville offered to print explanatory articles in lieu of ads as their company policy prohibits ads of any nature. Through these various publications a circulation of 10,800 readers, representing employees, customers and stockholders was reached. No charge was made for the space. The courtesy and cooperation of these companies is appreciated. A letter of thanks has been directed to the companies on behalf of the association. It is suggested that physicians having friends in these organizations may wish to add a personal "thank you." There may be other firms in your area which print employee publications, but are not listed in the national House Magazine Directory. If you know of any, please write the public relations office so that similar materials may be sent them.



Auxiliary Supports Letters-to-Congress Campaign:

Through the cooperation of Mrs. McMurry Wilkins, auxiliary president, and Dr. Charles Wyatt, advisor to the auxiliary, clearance was given to a program of coffees-and letters-to-congressmen at the time of President Kennedy's Madison Square Garden's health-care-for-the-aged rally. County auxiliary presidents were asked to contact their members, requesting that they invite friends in during the week of May 20-27. Names and addresses of S. C. congressmen, and writing materials were supplied for immediate action. Recent newspaper articles, reporting a flood of letters opposing King-Anderson, indicate that South Carolina had a part in a successful effort to block this bill. A warm "thank you" to all auxiliary members who took part in this drive.

Timely Witticism!

CALL A DOCTOR!

As we read President Kennedy's excited statement concerning the medical profession, we fear he may be suffering from hypertension.

Editorial: Charleston News & Courier, May 31.

NEW MATERIALS:

The order blank carries a listing of new pamphlets available through the public relations office. A limited number are kept on file. If you would like 25 or more the office will be glad to relay your order to AMA, or you may order directly from the Chicago office. The address is:

Department of Program Development
Communications Division
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

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THE FUNDAMENTALS

HARRISON L. PEEPLES,
Estill, S. C.

(Address to organizational meeting of SCALPEL, Wade Hampton Hotel, Columbia, S. C., May 17, 1962.)

I wish to thank each of you for attending this meeting on such short notice. We meet here to form a political action group which has the official approval of the South Carolina Medical Association and many of you were invited by members of Council. The appreciation for your attendance is in order.

When we attended medical college, I'm sure none of us thought it would be necessary to enter actively into politics. But this thing has been pushed upon us because of trends in our government which have become most distasteful. The facts are that there is a campaign under way to undermine our profession and to instill into our patients the thought that we are not dedicated to our work, that we're only interested in medicine for the material gain it offers us. Whether we like it or not our names (as doctors and members of AMA) are already in politics. We're sitting ducks and we don't have an effective instrument with which to fight back. Our in-and-out of politics is like fighting smoke when we need a permanent, voluntary, nonpartisan organization to fight the fire—Socialism. Remember you were citizens before you became doctors and you have the brainpower to protect your country. We have a disease (a malignancy, a cancer) in our society that will require radical surgery for cure. We intend to offer you an instrument to work with.

In this paper I shall spell out a proposed name for this organization and I urge each of you to JOIN and be ACTIVE. It's strength and effectiveness is not dependent on numbers alone. It depends on the amount of individual responsibility you assume and the amount of effort you put forth in fulfilling its mission. "It's time now", as Tom Anderson, Editor of *Farm & Ranch* magazine says, "to stand up and be counted—else you'll be counted out. We must think straight. We must believe in our GOD, believe in our COUNTRY, and believe in OURSELVES—in that order. The middle of the road between good and evil—is evil. When freedom is at stake, our silence is not golden—its yellow".

It's easy to stand with the crowd when they too are standing, but stand alone if you must when the cause is right and justifiable. There were men among our Founding Fathers who did just that. George Mason, the author of the Virginia Bill of Rights, and one of the "behind the scenes" leaders of the American Revolution was one of those. He was a member of the Constitutional Convention but was unhappy with the final document as originally passed. His objections were—First—that guarantees should be made that the federal government would not take away from the states their sovereign rights. Second—He wanted protection from the government so that individuals rights and liberties would not be abused. He stood alone in this and refused to sign the Constitution. He was proven correct—look what the Supreme court and Bobby Kennedy have done and are doing to the states now. Mason's second point was incorporated in the first Ten Amendments (The Bill of Rights) which set down protections for the individual. This was done shortly after the constitution was adopted. In the Virginia Bill of Rights, which George Mason wrote and which was adopted in 1776, there appears this statement in Article 15—"No free government or the blessings of liberty can be preserved to any people but by frequent recurrence to fundamental principles." I think he is correct again. We must return to the fundamental principles. What are the "Fundamental Principles" about which he speaks? Let's review a bit of our history.

Our forefathers were religious people having in common one single idea. They felt that they were free and that they were endowed with these freedoms by their creator. It was from their creator that their liberty was given them and not by the King or Queen, or their government. It came from a higher source.

These facts are set forth in our Declaration of Independence and I quote from the first paragraph, "The separate and equal station to which the laws of nature and of nature's God entitle them", second paragraph—I quote, "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain inalienable rights, that among those are Life, Liberty, and the pursuit of happiness." And in the last paragraph they appeal to "the Supreme Judge of the World" and they ask "protection of divine providence". Our founding fathers then gathered, believing that each man had within him a kindom of his own. He was fully free, with rights endowed to him by his creator. The only limitations on him personally were those found in the Old Testament. In the 10 Commandments the individual is told what he may NOT do—"Thou shall *not* kill", "Thou shall have NO other God before me", etc.

Based on these basic laws they wanted to bring about a means of securing this liberty of the individual for each of us and to form a common bond between them to protect the group from aggressors or those who would deny them these rights. So a government of the United States was formed with a Constitution under which we were to be governed. Our founding fathers set up a weak central government so as not to have too much influence over the individual. They wanted checks and balances so that no segment would be stronger than another; hence, the three branches of Government were formed, each with equal power. It is of interest that a republic, not a democracy was formed. A pure democracy is mob rule while a republic is bound by certain restrictions so that no segment of society could unite and depress minority groups. No group collectively should do to another group what they could not do to each other as man to man. Thus our government is bound by the same moral laws as you and I as individuals. The "Bill of Rights" gives the individual certain protec-

tions from Government. It told the government what it may NOT do to the individual just as the 10 Commandments tells the individual what it may not do against Nature's law—Law of God. For instance—"Congress shall make NO law respecting an establishment of Religion"—"NO soldier shall be quartered in any house without consent of the owner", etc. Our founding fathers had overwhelming fear of the power of centralized government. Thomas Jefferson said in a resolution, "..... It would be a dangerous delusion were a confidence in the men of our choice to silence our fears for the safety of our rights: that confidence is everywhere the parent of Despotism—free government is founded in jealousy, and not in confidence; it is jealousy and not confidence which prescribes limited constitutions, to bind down those who we are obliged to trust with power: that our Constitution has accordingly fixed the limits to which, and no further, our confidence may go .... In questions of power, then, let no more be heard of confidence in man, but bind him down from mischief by the chains of the Constitution."

Your liberty then is given to you by your Creator less those denied you in the teachings of the Bible, and those man-made laws which prevent you denying to others these same rights that they too hold. Our liberty is equal. You are a kingdom within yourself. You are free to do as you choose BUT you are accountable for your actions. This then is the moral code. The moralities of the issue and the source of all your liberty.

I've discussed our belief in God, and we must believe in our Country and assume the responsibility of electing to high offices in our government those people who have the same ideals and high standards based on moral law, free enterprise, individual liberty and individual dignity that we feel is necessary. Land, Capital and Labor are the tool of production everywhere. Government doesn't produce anything, but if allowed to grow too big, will produce little people. We want people in office who believe in Free Enterprise. Those who put less emphasis on the Free and more emphasis on Enterprise. We want people who will enact laws that encourage production and individual initiative so that we can make a bigger pie in America. We want to throw out those who develop their ulcers by lying awake at night figuring only ways to divide the pie we already have. We want people who will represent South Carolina in Washington, not those who represent Washington in South Carolina. As to political party at a national level, I personally can't see much difference in the 1960 platforms of the Super-liberal do good Democrats and the "me, too" Republicans. I wish both parties would disband and let's choose up sides again under different names. Then people could vote for the best man without voting like "Grandpappy" did. We need people like South Carolina's Strom Thurmond and John Tower on one side. People like Hubert Humphrey and Javits on the other. We'd then be honest with ourselves and mean what we say when we say we are Conservative or we are Liberal. We can't be Conservative on April 15, and Liberal the rest of the year. No reflection is intended on Democrats or Republicans as individuals. I refer to the platform influence makers like Chester Bowles and Nelson Rockefeller. If the Republicans would run Mr. Rockefeller against Mr. Kennedy of the Democrats, we would really be in a mess. We can't afford another rich man's son in office. They spend federal dollars like we have got as much money as their "Dads" had. We need a president who has worked to make a dollar, not just for exercise—a man who rolls up his sleeves to work, not to play golf. We need "experiencers" not social planners. Social planners forget the laws of nature and the moralities involved. Gentlemen, I farm a bit—I know about nature's law. I can always plan a good profit each spring at planting time but when analyzing the "farm loss" at the end of the year it was always caused by "it rained too much in July, too dry in August, or the Hurricane in September". I had not figured in nature's law—Law of Nature. So it is with social planners, they forget the moral laws—Law of God. The government that is big enough to give you everything is big enough to take all you have. Foreign aid is probably necessary and effective many places on earth, but let's help our friends, not communist sympathizers in socialist states to make their socialism stronger. Why spend excessive amounts of money fighting what we call tyranny abroad and in so doing produce a form of tyranny at home by excessive taxation and controls?

There are many benevolent laws which may have in their beginning some good, but they have always been a foot in the door. They produce power in the hand of evil men. Federal aid is a farce—you can't have federal aid without controls. The government can't give you money without taking it from someone else. Why fool ourselves. For some reason many politicians who develop power by coercion (Federal aid, Civil Service jobs & benevolence) feel that they automatically develop wisdom. A man with power and self-endowed wisdom is dangerous. He closes his mind and does as he pleases all in the pretext of "general Welfare".

WE MUST BE HEARD.

Our Declaration of Independence states that we are created equal and endowed with inalienable rights, among these are Life, Liberty and the Pursuit of Happiness. We are equal in our creation but it's how we use our talents endowed to us that make us different and unequal in our station. We each differ—physically and mentally—no two fingerprints are alike. Free men are not equal and equal men are not free. In the communist world men are equal, but they are all subservient to the state. In America we are offered equal opportunity. We are not guaranteed anything. We can be self sustaining or a bum—all on our own efforts.

We spend billions each year on foreign aid in pretense of fighting communism. Sure—there is always danger of all-out nuclear war with Russia or with

some other communist states. We must maintain a strong armed force to protect us from external aggression and that in our government responsibility, not the United Nations. We've got to get our state department thinking in terms of what's best for America—not what's pleasing to the United Nations. Our State Department's action is like this—"we're neutral to our enemies, friendly to the neutrals, and hostile to our friends". There can be no neutrals between atheism and love of God. An agnostic won't do—he just hasn't studied the issue. Sure, our older people need help, but not direct gifts from federal agencies, unless ill, not extra benefits under social security which would be paid by younger people through ever increasing social security tax. The really needy do need assistance. That's why all doctors supported Kerr-Mills bill which does a good job in our State. By the way, what happened to the fifth Commandment? Kerr-Mills does not suit the "planners" because there is no coercion there for them, it's managed by the States and Counties. Our older citizens would not be in the financial trouble now if our government had not broken its contract to maintain a stable economy. We hear so much about growth rate in America. It must be a figure of speech only—we are in debt over 300 billion dollars, yet our growth rate is up 3 to 5% annually, they say. I'm for stopping growing unless we can cut the dollar appetite. Someone once asked Walt Disney if he wasn't a millionaire, his reply—"Well I must be; I owe ten million". Maybe that is the way it works. I'm told that in economics the thinking is now that it's what you spend—your own or somebody elses—that makes us grow, not what we produce. No wonder the U. S. Chamber of Commerce had to have written an economic course that describes free enterprise.

In *Nations Business*, April, 1962, there is an article entitled "Planners urge Federal Land Control". This is a shocker! Planners would divide all land into one of eight classes, each acre would be classified as to permitted use. There would be a 30 mile wide green belt to ring all cities. No homes, no industry, no commercial activity here—this would be for recreational purposes only. Another sleeper! "The proposed rural renewal program would permit the establishment of what the President called local public rural renewal corporations. The federal government would lend money and provide technical assistance to these new public bodies. The corporations would have the power to buy up farm land, put several small farms together into an acreage deemed big enough to farm profitably and then sell the land to a single farmer under long-term, low-interest, government-backed mortgages. As under the urban renewal program, the owner of land wanted for rural renewal would have no choice but to sell to the government." Now we've heard of agrarian reforms in Cuba and elsewhere, but this IS different. The Planner will not divide the large acreages. They do it in reverse—take the little fellow first. What has happened to the individual dignity of man—A man's house is his castle.

Someone has asked me since I disapproved of these so called social reforms if I would like to turn the clock back to the '30's. Of course I do not want to turn the clock back, but I see people weekly who have been in auto wrecks—they all wished the clock could have been turned back to the moment just before impact. It's the wreck of our society that worries me. We need brakes. Too much power corrupts, absolute power corrupts absolutely.

If you read the communist bible—the Manifesto written in 1848, you see that the plan to overthrow capitalism is by "winning the battle of democracy" and by "raising the working class to the position of ruling class". A capitalist to them is anyone who owns land, a house or car; therefore, most in South Carolina to them are capitalist.

We see today in America what we call "Creeping Socialism". It makes me feel that our enemy is different from what I figured. I had always thought communism intended to take us by violence. Now I find the goal is to be achieved not by bullets, but by ballots; not by illegal, but by legal means; not by evil persons but by vote of the majority. We in America have been asleep and have chosen the wrong battlefield at the wrong time and against the wrong enemy. We must watch our home front as well as foreign fields.

We can accomplish our mission by political education which must be given to ourselves and to others. YOU are all strong people, heavily endowed by your Creator with sufficient "gray matter" to do the job. Let's use it.

We as doctors of medicine see people daily and treat people daily in our effort to restore them to a useful life. We must work for the lives of our children and for the lives of those still unborn, as well as for the lives of our patients—*as to life*, you have a full understanding.

I've spoken about Liberty, Political Education and Life. These things come in natural order when we think of God *first* who gives us our Liberty, our Country *second* which can only be maintained as we want it by political education, and we think of ourselves *third* in reference to our life, our children's life, and the life of our patients. Our society is sick. There is a cancer undermining us. The disease needs radical surgery. This organization would like to be the instrument with which to work. I propose then that it be named South Carolina Alliance (for) Liberty, Political Education, and Life. The initials spell—SCALPEL. I propose that we support it fully, so that the flag of the United States of America will again represent the basic moral belief and show the strength and pride for which we will stand. We want our flag to represent a nation of people who have full liberty, but who have discipline and control from within each individual, based on moral laws, not disciplined by the State. "Man ultimately will be governed by God or tyrants", said Benjamin Franklin. Let us make that decision and stand up for it.

A poet expresses it better than I. He has this to say in reference to our American flag, the flag that means so much to us.

I am not the Flag, not at all
I am but its shadow
I am whatever you make me, nothing more.

I am your belief in yourself,
Your dream of what a people may become

I am the days work of the weakest man,
And the largest dream of the most daring

I am the clutch of an idea, the reason
Purpose of resolution.

I am no more than you believe me
To be, I am all that you believe I
Can be.

I am whatever you make me,
Nothing more.

Medical Care For The Aged— How Will You Have It?

ALVIN J. INGRAM, M. D.
MEMPHIS, TENN.

Organized medicine, beginning with your doctor friends and neighbors who belong to their local County Medical Society, their State Medical Association, and who operate the American Medical Association believe that we, and that includes all responsible citizens, should help those who need help, to the extent and for the period of time that they need such help. As a correlary to this belief, we believe that except to meet a definite need, no arbitrarily determined segment of our society should ask for or receive special privileges at the expense of the public. An existing need should be met by the individual or governmental unit as close to the recipient as possible, beginning with the family, community, church, city, county, and state, and when these agencies and individuals fail to provide the necessary care, then the Federal Government should meet the needs. The services should be provided with an attitude of charity and generosity on the part of the donor and there should be no stigmata associated with this humanitarian action.

Secondly, we are aware of the fact that it is necessary for most people to be able to pay for their health care on the installment plan basis, just as they currently do for all of the luxuries and most of the necessities of life today. Because of inflation, high taxes, the widespread expansion of individual credit, few people are able to withstand a sudden loss of income, an unexpected expense, or both, without personal financial calamity. Organized medicine, with a very strong assist from voluntary health insurance is making, and will continue to make, tremendous advances in this area, if we are given the continued opportunity.

We believe that the basic role of government in dealing with its citizens should be to help them to help themselves, not just in the health care field, but in all of its fields of endeavor.

One of the principal ways in which the government could help us all would be to stabilize our currency. The individual who retired on $100 per month in 1940 finds that his $100 is worth $45.00 now in terms of purchasing power as compared with 1940. Must our currency continue to lose one-half of its value every twenty years? If so, how long can this go on? I don't claim to know the answer to these problems, but the anticipated 7 or 8 billion dollar budget deficit for this year leads me to believe that this could be a very fruitful topic for a "White House Conference" of the currently popular grass roots variety.

Another way which government could possibly help would be to assist economically border line individuals, those who are likely to be wards of the government when adversity strikes, to help insure themselves against some of their most common serious risks, such as unemployment and illness.

The basic problem of our times, however, is not financial, or medical, but sociological. As a result of the growth and the urbanization of our population, the mechanization of industry, the weakening of our church and family ties, our people are developing a rootlessness, a loss of a sense of personal identification with and personal responsibility for our own lives, those of our family and neighbors, and for our

An address delivered at the Alumni Banquet, Myrtle Beach, S. C., May 10, 1962.

government at all of its administrative levels. Phrases like payola, kick-back, something for nothing, let big brother do it, ADC, juvenile delinquency—these are all recently coined phrases. Each one carried its own distinctive meaning and each is thoroughly understood by us. Collectively they must be considered to be symptoms of the worst disease which could affect our form of government, namely apathy, decay, erosion, and collapse. How sick must the patient be before we begin the treatment? Wise men have said that the ability of a people to rule themselves can be measured by their selfrestraint and their personal responsibility. The end of a democratic republic begins when the people begin to vote themselves special favors and privileges from the public treasury.

The chief problem of the aged today is likewise not medical nor financial, but a sociological one. Actually medical science is assisting in keeping more people alive longer today than ever in history, but has society permitted them *to enjoy* these extra years? I say society has not quite met this responsibility. Compulsory retirement at age 65, probably soon to be 62, of capable, active people, their segregation into social and now into political groups, the age of the small apartment, of husband and wife working, of the tremendous boom in nursing homes, of the national accent on youth, all of these and many other factors make our senior citizens feel that they are discards, they are obsolete, that they are citizens emeritus and unwanted. Our senior citizens don't want to simply wait to die, but just like you and I, want to be a part and parcel of their environment, they want to be consulted, to belong, to be loved, they would like to feel that their skills and lives still have some value, and that these will be used and appreciated. This is the over-riding problem of the aged, if our congress, our President, or our Supreme Court are interested in sociology, this would be a good starting point for some constructive thought and action.

These are some of the problems of the aged. American medicine is exerting every effort to help our society effect a solution to the problems within the framework of a free society by positive and continuous action.

Our Congress is under tremendous political pressure at this moment to pass a bill which we believe would compound these problems and which would thus be opposed to the best interest of the citizens of our country. If you think this bill only concerns the aged, the doctors, and the "new frontiersmen", you are in for a rude awakening on two scores. In the first place, it will be our youth and not the doctors who will pay the price if and when this Bill passes, and secondly the doctors cannot win this battle alone. Without the active interest and participation of responsible citizens like yourselves, this bill or one similar to it is bound to be enacted sooner or later, and when it is, the flood gates will be permanently open for the flood of welfare state legislation.

As an individual doctor and as a member of organized medicine, I am opposed to the enactment of this Bill for several reasons.

1. A superior Bill has been enacted into law.
2. Instead of being an attempt to satisfy a demonstrated need, this Bill is subterfuge whose ultimate purpose would be further centralization of our government and of the control of our lives.
3. It would be oppressive to much of the American Way of Life.

In October of 1960, the Congress of the United States enacted the Kerr-Mills Medical Aid to the Aged Law. This Law was implemented by the Tennessee Legislature in 1961 and went into effect in Tennessee on July 1, 1961. Briefly the Bill permits the United States governmental general fund to grant money to the various states according to a matching formula which is determined by the per capita income of the people of the state. In Tennessee approximately one-fourth of the money in this program is provided by the state and three-fourths of the money is raised by the Federal Government. The only requirements connected with this Bill are that the help be rendered on the basis of need, that it be spent on people 65 years of age and older, and that in-patient, out-patient and drug services must be provided in the program. The determination of who, what, when, where, and how the assistance is given is made by the state. We are convinced that the various state governments which are nearer to the problems of its people, will be more responsive to their wishes, and as a matter of fact recent events in Tennessee have already shown this to be true. The MAA Plan in Tennessee was started on a very conservative basis. The Tennessee doctors have consulted the governor on several occasions, recommending needed expansion of services, and within the first seven months of operation the program was expanded three times. It will be reviewed again after one year and we will press for further liberalization consistent with need and fiscal responsibility. Incidentally you might be interested to learn that the doctor receives no payment for his services under this plan.

The King-Anderson Bill on the other hand has many objectionable features. First of all, each and every determination is finally made by the Secretary of Health, Education, and Welfare, and through the "power of the purse "this makes him the Czar of the Hospital Industry. The services would be rendered regardless of need to all over 65 years of age who are covered by social security; rich or poor, retired or working, janitors, maids, corporation executives, and even Chairmen of the Board. The funds would be raised by a tax on the younger productive members of the society who pay into the social security system; those same children of ours whose heritage is already a three hundred billion dollar national debt, and whose social security system today has outstanding obligations of at least three hundred billions of dollars. They will also be paying the monthly premiums on the "paid up life time policy of health insurance" which was promised to the senior citizens by Mr.

Kennedy, in 1960. Part of the premium will be paid by the wages withheld from them and the remainder by business. Since profits are already at a minimum, this cost will be passed to the consumer by inflation of the prices they pay for the products and services which they purchase. When we contemplate these facts, the ground swell of conservatism in our colleges is understandable. I wonder what would be the extent of their resentment and indignation if they really understood the financial heritage the present generation is passing on to them. Finally, the Bill makes no provision to care for at least three million needy aged individuals who are not covered by social security. As a matter of fact, Mr. Ribicoff now advocates that the Kerr-Mills Law be retained for use for these needy individuals, thus admitting by implication that this Bill is superior to the one which he now proposes.

I consider the Bill to be a subterfuge, because it is alleged to be insurance and is not, and because it is alleged to not be socialized medicine while it is socialized medicine.

When the proponents of this Bill speak of it as insurance, they conveniently omit the work "social", and I am sure that you realize there is a great deal of difference between social insurance and what the average citizen calls insurance.

The social security mechanism simply raises funds by a current tax on the productive people to pay the cost of benefits which are currently due to the recipients. The supreme court has ruled that it is tax, and is not a contribution, and that the covered individual has no equity in the fund. There is no contract, no cash value, and no benefits are guaranteed. Thus the social security system does not qualify as what you and I understand to be insurance. The fact that the benefits have been liberalized by every session of Congress in recent memory reinforces the opinion that this is one of the greatest "vote getting" and one of the least publicly understood political devices in Washington. Thus, what the public has been told is insurance, is technically social insurance, which appears to me to be actually "political insurance".

As originally conceived, social security was to provide a basic floor of protection against want and destitution. Benefits were granted as cash and not as services, and the amount of money paid a recipient had some relation to the contributions and to the earnings of the individual covered. Now a paternalistic government desires to put a carpet on the floor by providing services instead of cash. Those who have raised families, defended their country in war, guided our business, our industry, and government suddenly upon reaching their 65th birthday are no longer able to spend money wisely. Now, big brother must buy the services the citizens need, beginning with the health care. The questions naturally follow, when will housing, food, clothing, legal services, and recreation be provided by the government. Ridiculous you think? Let me remind you that the total employer, employee tax for governmental social services is now 37% in Italy, 33.5% in France, and is over 24% in West Germany. It is already scheduled to reach more than 9% by 1970 and will probably exceed 10% if HR 4222 is enacted. Let me make it perfectly clear that as originally conceived, social security is a definitely worth while system. We must now answer the question, is the social security system a suitable area for pressure politics for minority favors? Secondly, how much additional inflationary pressure can our economy stand? Thirdly, is it morally proper for us to continue to pass our debts onto our children? My answer to these, the reason for my presence here today, is a resounding no.

Concerning socialized medicine. The Bill states that the hospital will make arrangements to provide four specific types of medical services, namely anesthesiology, radiology, pathology, and physical medicine. These arrangements between the hospitals and the doctors concerned will be subject to the approval of the Secretary of Health, Education, and Welfare. Thus, through the powers of the purse, he would have the final control of these four medical specialties. To say that this is not socialized medicine is an evasion of the truth.

Finally, this bill is a subterfuge because it is purely and simply an opening wedge. President Kennedy says that this Bill is "just a beginning." Walter Reuther has stated "it is no secret that the UAW is on record as backing a program of national health insurance" ex-Representative Aime Forand stated "if we can only break through and get our foot inside the door, then we can expand the program after that."

The doctors of America believe that the people of this country would and should overwhelmingly defeat any open and above board attempt to socialize medicine in the U. S. and, thus, we have attempted and will continue to attempt to strip the disguise from the Bill and to label it what it is—political medicine.

This group today demonstrates the fruits of the free enterprise system. Gentlemen, if this Bill becomes Law there are two industries which will be lost from the ranks of free enterprise—the Hospital and Nursing Home industries. The Secretary of Health, Education and Welfare is authorized through the mighty powers of the purse to exercise control over hospitals, facilities, and agencies providing the services. *One of the basic facts of life today is that government controls what it subsidizes. That is the way it is, and that is the way it should and must be. He who pays the fiddler calls the tune. The tune was not pleasant to the steel industry, it was not pleasant to our friend the Arkansas farmer who recently had his farm confiscated and sold at auction.*

What our government should do is supplement, not supplant; help, but not control its citizens. The single factor which has made the American Way of Life the best that the world has ever known, is the dignity

possessed by the individual citizens of America. We often hear of these characteristics, but seldom do we stop to analyse the source of this dignity. In my opinion, it derives directly from the characteristics of the free enterprise system. Freedom of choice, Freedom of action. Thrift, self reliance, self discipline, and individual responsibility for himself, his family, and his government, these are the characteristics which have bestowed upon the citizens of this country that measure of dignity which they have attained, the greatest ever attained by the citizens of one country in the history of the world. Are we willing to give up these characteristics, to say that they are old fashioned, to say that they are impractical? If so, then we should support the Bill that I criticise today, for it would be one long step along the road toward total centralization of our government and the development of a welfare state.

On the other hand if we believe that these characteristics are needed today more than ever in the history of this country, as I do, then you must assume the basic responsibility of every true American, which is to maintain the American Way of Life and to pass it intact to succeeding generations. This is your responsibility. Ask not for whom the bell tolls—it tolls for you and me, and if you favor my position, then you must exert every effort to see that we are governed by constitutional law, and not by administrative edict. That the government is by the people, and not for the people. That the government serves the people, and it does not control the people. We must fight for freedom for all people on all fronts, and not simply for our own.

We must realize that the present battle is an ideological one, fought in the political arena, and that the individual is gradually losing his freedoms, prerogatives and responsibilities to the growing central government.

To be effective in this fight we must join a political party, select, elect, and supervise candidates who agree with our philoscphy and finally we must assist our government officials to maintain our system by establishing a climate of public opinion favorable to such actions.

We could begin tonight by sitting down and writing our Congressmen.

I would like to conclude by a quotation from America's greatest humanitarian.

"You can not bring about prosperity by discouraging thrift. You can not strengthen the weak by weakening the strong. You cannot help the wage earner by pulling down the wage payer. You cannot help the poor by destroying the rich. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away men's initiative and independence, and you cannot help men permanently, by doing for them what they could and should do for themselves." These are words spoken by America's greatest humanitarian, Abraham Lincoln, in 1863. No words could be more appropriate for meditation by the citizens of this country today.

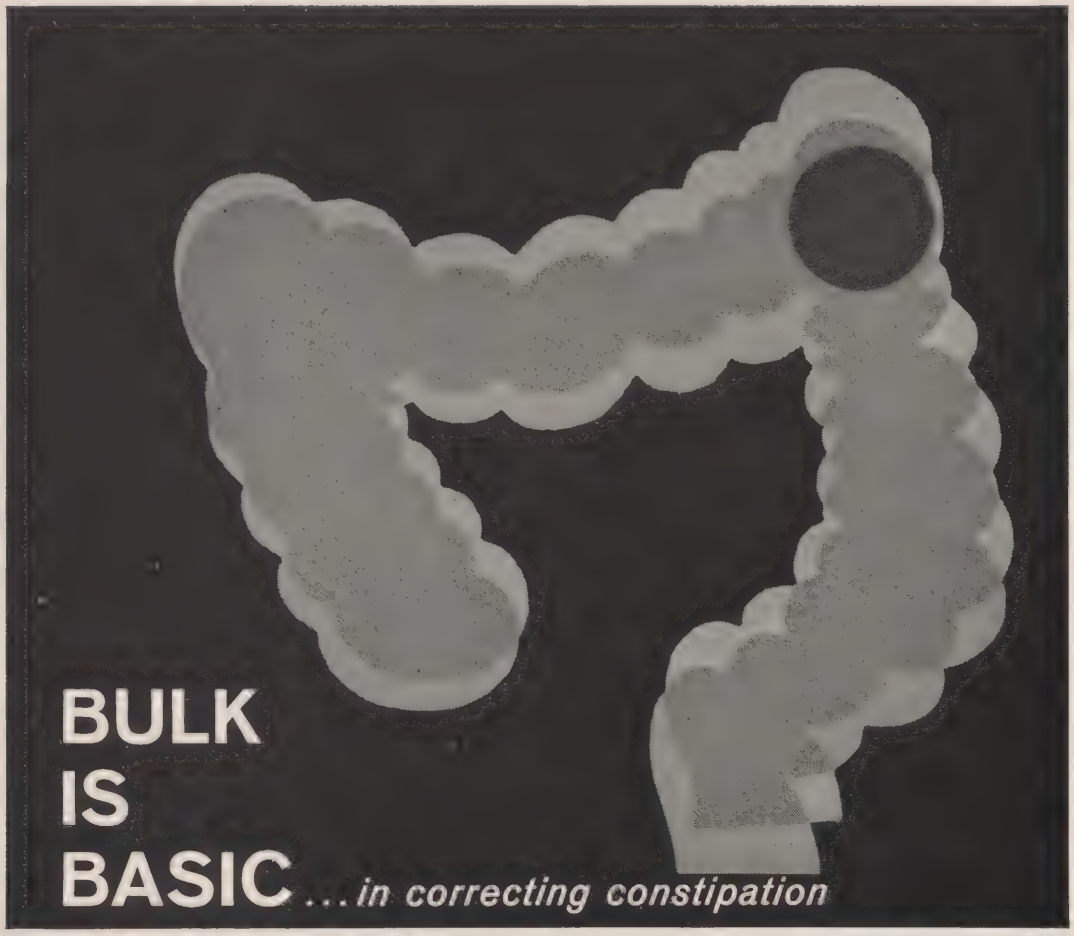
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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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Research in the Service of Medicine

Deaths

DR. WILLIAM WESTON

Dr. William Weston, 87, dean of Columbia's physicians and a leader in the field of pediatrics throughout the United States for half a century, died June, 17, 1962.

Although Dr. Weston had been in declining health for some time, he visited his office located adjacent to his home at 1231 Bull Street each day until a week before his death.

Dr. Weston, who had practiced medicine since 1897, was born on a family plantation, The Oaks, near Eastover on August 6, 1874. He was the son of Dr. William Weston, also a physician, and Caroline Elizabeth Woodard Weston.

Dr. Weston was the sixth William Weston to live in the lower part of Richland County, and his son, also a Columbia physician, and a grandson have the same name.

A lifelong member of the Episcopal Church, Dr. Weston received his undergraduate education at the University of the South, an Episcopal institution located at Sewanee, Tenn.; he remained a loyal supporter of Sewanee throughout his life and made substantial contributions to his alma mater. He received his medical degree from the Medical College at Charleston and he also studied at Harvard University in Boston and Columbia University in New York.

PRACTICED IN 1897

Dr. Weston began his practice in Columbia in 1897. He was at first a general practitioner, but in 1912 he became a second doctor in the South to limit his practice to pediatrics.

When he returned from World War One, Dr. Weston found the Columbia Hospital in great debt; he led a campaign to pay off the indebtedness and was able to head a labor campaign which resulted in the hospital's becoming a county agency. He later served as chief of the medical staff at Columbia Hospital and was for some years chairman of its board of trustees.

Dr. Weston was a regular member of the teaching staff of the Summer Medical Seminars conducted in the field of pediatrics each summer for many years at Saluda, N. C., and led by Dr. Lesesne Smith of Spartanburg. Although his medical research took him into many fields of medicine and nutritional study, it was primarily to the field of pediatrics that Dr. Weston devoted his study and research.

IDENTIFIED ACRODYNIA

Dr. Weston was the first physician in the United States to identify acrodynia. He also was a leader in the study of pellagra, a disease caused by dietary deficiency. This lifelong study of nutritional values as related to medical research made Dr. Weston a leader in the treatment of illnesses through proper diet; he presented the first vitamin chart to the Scientific Section of the American Medical Association in 1928.

In his studies at Bellevue Hospital in New York after he determined to specialize in pediatrics, Dr.



Weston learned the value of Bulgarian milk with which he treated numerous cases of infectious diarrhea, before discovery of antibiotics. Dr. Weston wrote many articles for leading medical journals and textbooks on nutrition and pediatrics. His son, Dr. William Weston Jr., practiced with him for many years, and two grandsons, Dr. William Weston, III, and Dr. Shannon Nelson Weston have entered the pediatric field.

Dr. Weston organized the section on pediatrics in the Southern Medical Association in 1916 and he was councilman from South Carolina to the Southern Medical Association for eight years. He had already served as president of the Columbia Medical Society and was president of the South Carolina Medical Association in 1913-1914.

A founding member of the American Academy of Pediatrics, Dr. Weston was 13 years the delegate from the Pediatrics Section of the American Medical Association. His honorary degrees included a Doctorate of Public Health from The Medical College of South Carolina, a Doctorate in Science from the University of the South, and an LL.D. from the University of South Carolina.

Dr. Weston's most interesting contribution in the field of medicine resulted in an appointment as chairman of the South Carolina Food Research Commission in 1927.

The Commission was organized to publicize the advantages of South Carolina produce from a health viewpoint, and Dr. Weston traveled throughout the United States in connection with this work. For several years, South Carolina was known as The Iodine State; the work of the Commission was discontinued during the depression of the early thirties.

Dr. Weston established the first hookworm clinic in the United States. More than 1,500 cases of hookworm were treated, and the health problem among the mill's workers was solved.

Book Reviews

SHOCK — PATHOGENESIS AND THERAPY. An International Symposium Chairman, U. S. von Euler. Editor K. D. Bock. Sponsored by Ciba. Springer-Verlag. Berlin - Goettingen - Heidelberg, 1962. 387 pp. $13.00.

About 40 selected investigators from several countries participated in this discussion at Stockholm during June 1961. Their varied type of experience indicates prior effort to obtain a careful balance of background in both basic science and clinical observations. They define "shock" as any grade and duration of reduced capillary blood flow leading to tissue hypoxia with functional or morphological changes. In most discussions, they have adequately defined the type of shock under consideration and the coverage includes particularly that due to hemorrhage, trauma, burns, endotoxins, coronary insufficiency and histamine release. Sound estimates are presented on the relative therapeutic value of drugs which are sympatholytic and those which are sympathomimetic, on corticosteroids and on the dextrans of both high and low molecular weights.

R. P. Walton, M. D.

PSYCHIATRY—BIOLOGICAL AND SOCIAL. By Ian Gregory, M. D. W. B. Saunders Company. Philadelphia and London. 1961. $10.00.

Dr. Gregory has attempted to write a textbook for psychiatry, which would incorporate the most acceptable studies of each school of thought in this diverse field. His eclectic approach is admirably accomplished. The technical quality of the psychiatric information, both theory and substantiated research studies, is up-to-date and concurrent with present thought in this field. One is almost tempted to say that the style of writing is unique, in that it is clear, concise and has beauty in its simplicity unlike much psychiatric communication. The sum of these attributes makes this book valuable in its primary role as a textbook, but in addition, should serve as a valuable basic book in any physician's library. This book is recommended as a source of psychiatric knowledge without qualification.

This will become one of the three basic textbooks in teaching psychiatry at the Medical College of South Carolina.

William C. Miller, Jr., M. D.

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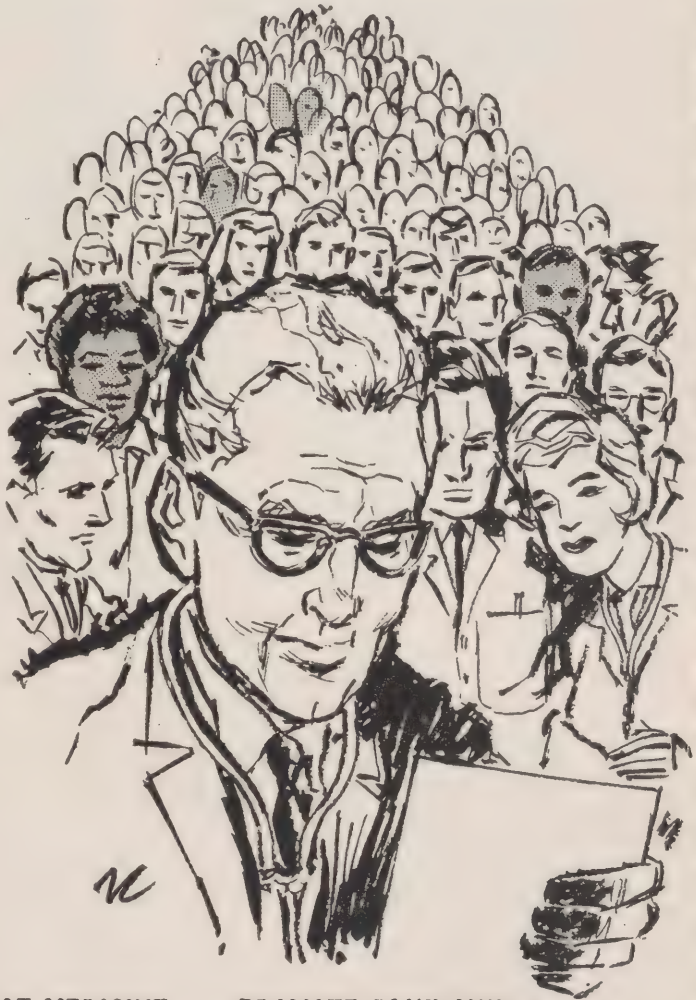
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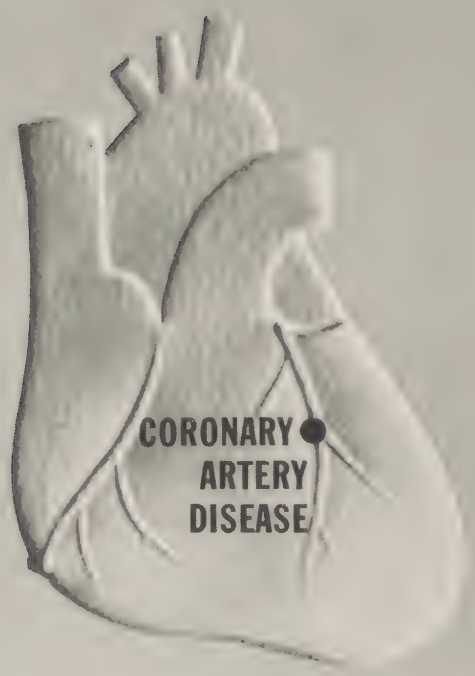
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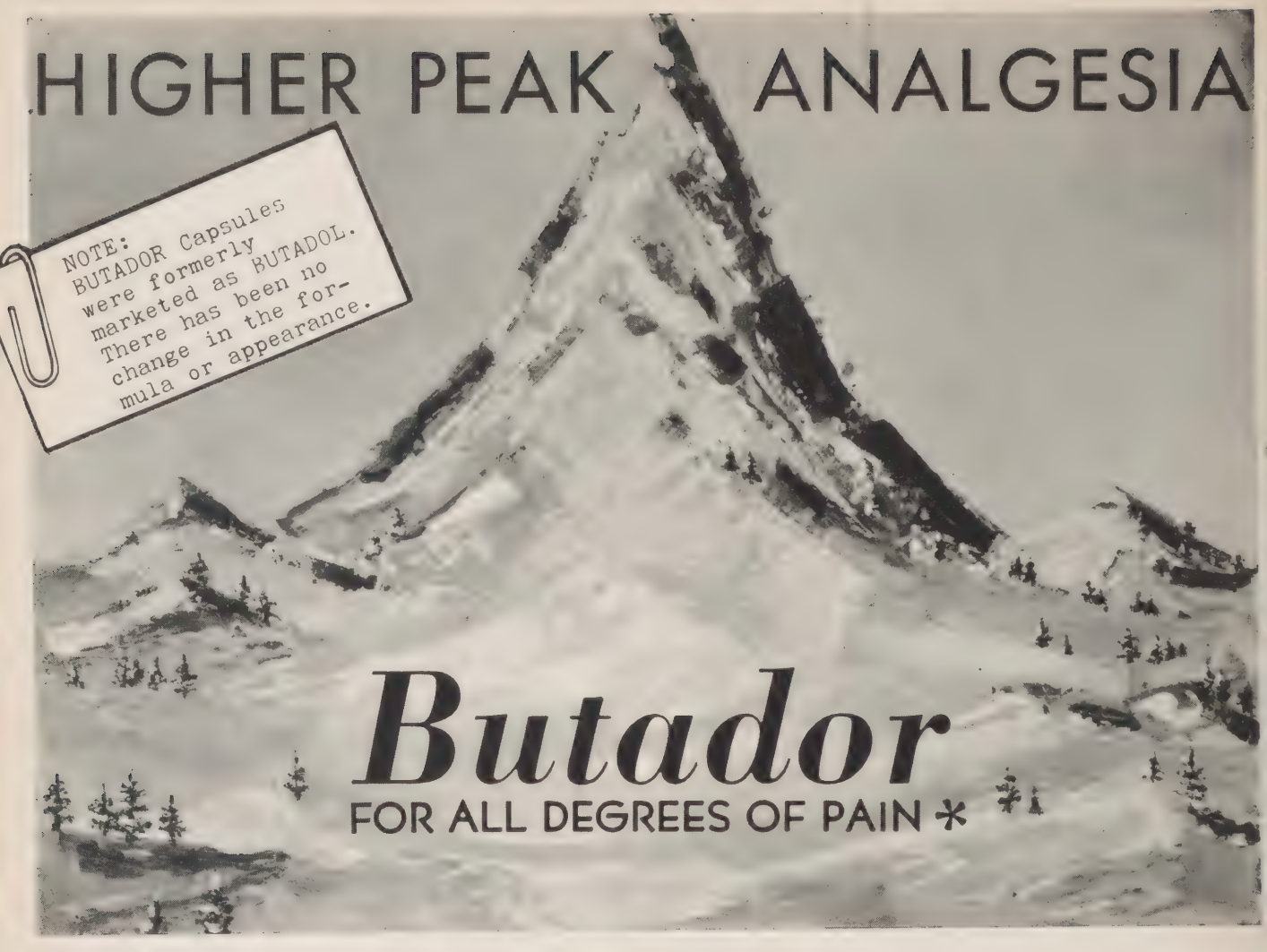
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If you are now prescribing the newer corticosteroids— such as triamcinolone, betamethasone, paramethasone or another brand of dexamethasone, because of reduced risk of sodium and fluid retention, potassium depletion, or disturbance of glucose metabolism—you can obtain all of these benefits with HEXADROL, at marked savings—yet with complete assurance of unsurpassed quality and therapeutic effect.

For complete information concerning HEXADROL— including indications, dosage, precautions and side effects—or if you would like a trial supply, ask your Organon Representative, or write to: Director, Professional Services, Organon Inc., West Orange, N. J.

'Organon'—your professional assurance of quality
Hexadrol®—your patient's assurance of economy!



in arthritis: vitamins <u>are</u> therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

663 gentle doses of iron in a single capsule, once daily

ONE-IRON™

(capsules of timed-release ferrous fumarate)



the best-tolerated ferrous iron
timed for release in the area of maximum absorption

A single capsule of ONE-IRON—taken once a day by your iron-deficient and even your iron-sensitive patients—sprinkles tiny particles of ferrous fumarate throughout the duodenum and jejunum over a four-hour period for virtually complete and trouble-free absorption.

Not only is maximum hemoglobin regeneration obtained, but the possibility of gastric discomfort, diarrhea or constipation from ionized iron is virtually eliminated.

Moreover, ferrous fumarate itself (the sole active ingredient of ONE-IRON) is better tolerated than ferrous sulfate, succinate or gluconate.[1-3]

Each timed-release ONE-IRON capsule provides ferrous fumarate, 325 mg. (5 grs.), equivalent to 107 mg. of elemental iron.

Dose—one capsule daily with breakfast.

Supplied—bottles of 100 and 1,000 clear and white capsules.

References: 1. Berenbaum, M.C. et al.: Blood 15:540, 1960. 2. Shapleigh, J.B. and Montgomery, A.: Am. Prac. & Digest Treat. 10:461, 1959. 3. Swan, H.T. and Jowett, G.H.: Brit. M.J. 2:782 (Oct. 24) 1959.

HART LABORATORIES
Division of A. J. Parker Co.
Winston-Salem, N. C.



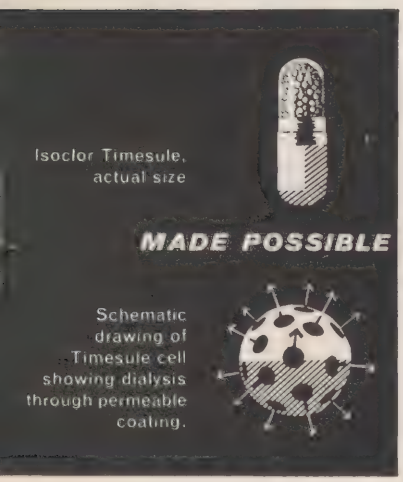
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Around the clock relief for HAY FEVER DISTRESS

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A NEW COMPREHENSIVE RELIEF

- **Relief usually starts in minutes**—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
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- **With minimal** drowsiness, CNS or pressor stimulation



MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

EACH ISOCLOR TIMESULE CONTAINS:
Chlorpheniramine maleate . . . . . 10 mg.
d-Isoephedrine HCL . . . . . 65 mg.
In a special form providing prolonged therapeutic effect.

DOSE: Adults: One Timesule every 12 hours, or as directed.

WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CHARLES C. HASKELL & COMPANY
Richmond, Virginia

DIV ARNAR-STONE LABORATORIES, INC.



Trocinate®

Brand of Thiphenamil HCl.

A MUSCULOTROPIC ANTISPASMODIC WITH NO APPRECIABLE ANTICHOLINERGIC ACTION

Trocinate relieves spasms of the lower bowel and the genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma.

USUAL DOSAGE: 2 Tablets, 4 times a day. Maintenance dosage is frequently lower.

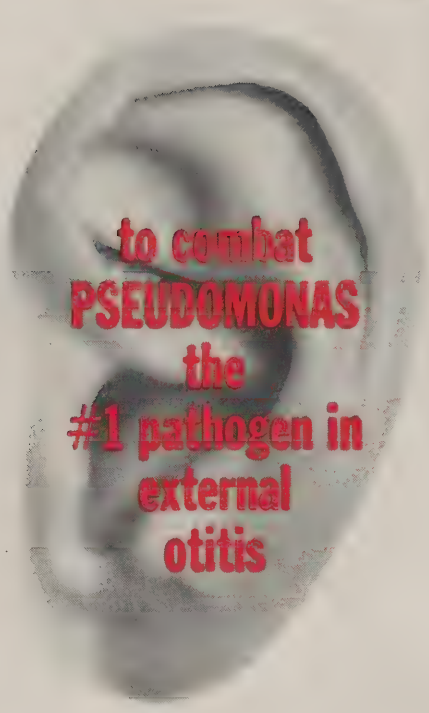
Available in PINK sugar-coated tablets, 100 mgs. and in GREEN sugar-coated tablets of 100 mgs. with 16 mgs. of phenobarbital.



Dispensed in bottles of 40 and 250 tablets.

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Manufacturers of ethical pharmaceuticals since 1856



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brand

OTIC DROPS (sterile)

the #1 therapy for inflamed, infected ears

Because it provides Polymyxin B for the eradication of Pseudomonas, the prime cause of external otitis, 'Cortisporin' is the logical choice of treatment for inflamed, infected ears. Polymyxin B is the antibiotic specific for *Pseudomonas aeruginosa* infections, and is, for this pathogen, the standard of effectiveness against which other antibacterials are measured.

- Anti-inflammatory
- Antipruritic
- Antibacterial



Each cc. contains:

'Aerosporin'® brand Polymyxin B sulfate	10,000 units
Neomycin Sulfate (Equivalent to 3.5 mg. Neomycin Base)	5 mg.
Hydrocortisone	10 mg. (1%)

Bottles of 5 cc. with sterile dropper.

Literature available on request.

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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE:** 1 **TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

In summer diarrheas



prompt 4 way check

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

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Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 ml. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 ml.

(equivalent to 2 ml. paregoric)

Warning: May be habit forming.

DOSAGE: **Adults**—Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children—½ teaspoon (=2.5 ml.) per 15 pounds of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 1 pint (raspberry flavor, pink color)*

Exempt Narcotic. Available on Prescription Only.

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in the wide middle region of pain

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(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) TABLETS

fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

Literature on request

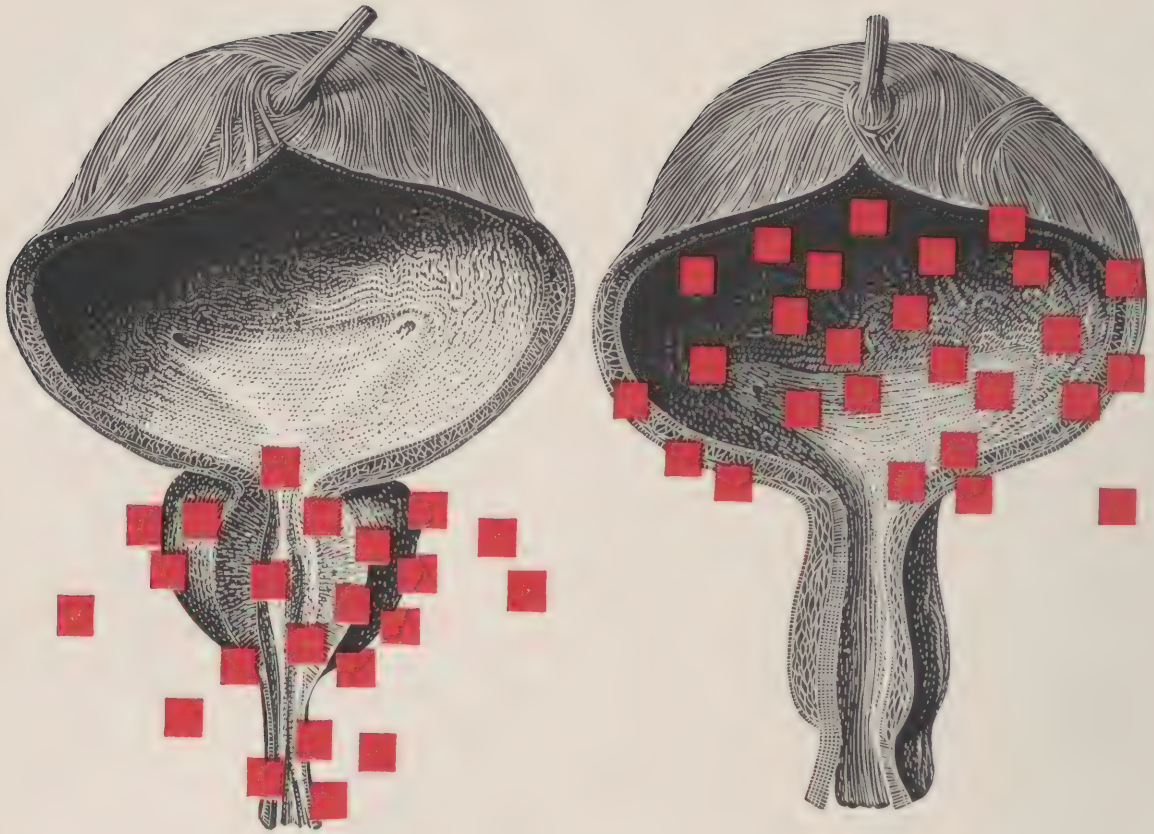
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Richmond Hill 18, New York

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768



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Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

SQUIBB *Squibb Quality—the Priceless Ingredient*

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Emotional control regained...a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

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Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

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brand of chlorpromazine

A fundamental drug
in both office and hospital practice

Posed by professional models.

For prescribing information, please see PDR or SK&F literature.



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ANGINA PECTORIS

ANTORA...

PROVIDES 10-12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

ANTORA-B...

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate plus 50 mg. Secobarituric Acid. Medication is released over 10 to 12 hours with fewer side effects and less "hangover" than the longer acting barbiturates. As with Antora, capsules are administered only twice daily instead of the usual 8 to 12 tablets. Administer with caution in glaucoma.

REFER TO PDR
PAGE 643

Supplied: Bottles of 60 and 250. Literature and clinical samples available.

Maynard, inc.

PHARMACEUTICALS
1042 WESTSIDE DRIVE
GREENSBORO, NORTH CAROLINA

THIS IS THE COLOR OF PROTECTION



BETADINE—The only germicide whose color indicates a germ-free environment—provides lasting protection and is the most potent non-irritating topical antiseptic known.

for the first time...
a universal microbicidal agent that does not sensitize or retard healing

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Kills bacteria, viruses, fungi, yeasts and protozoa on contact. Non-injurious to skin, exposed tissue or mucous membranes.

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APPROVED
FOR MEMBERS OF
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MONTHLY BENEFIT FOR LIFE..$300.00
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MONTHLY BENEFIT first
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(and in addition, the monthly and hospital benefit for the period between date of accident and date of death)

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$100.00 ADDITIONAL MONTHLY BENEFIT FOR TOTAL DISABILITY for as long as one year is available by rider.

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POLICY CONTINUANCE AGREEMENT for members of the South Carolina Medical Association.
Disability Benefits begin with first day of disability and medical attention.
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One of the oldest and largest institutions of its kind in the World specializing in Professional Disability Income.

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OVER FIFTY

YEARS CONTINUOUS

SERVICE!

"MILLIONS PAID IN CLAIMS"

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Check ☐ S. C. M. A. MEMBERS MAKE INQUIRY TODAY

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I would like full information in regard to changing my present coverage to the above which is optional.

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Columbia, S. C.

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Applicants must meet the underwriting requirements of the Company. (865-579)



Supplied: Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:
Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.
Usual pediatric dosage:
½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.
(*Reminder advertisement.* Please see package insert for detailed product information.)

*TRADEMARK, REG. U.S. PAT. OFF.
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Upjohn

Liquid asset

Now that we have added a new liquid-dosage form to our Panalba* family, you may prefer to begin treatment with Panalba KM* Drops when dealing with bacterial infections of unknown etiology in infants and children. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most bacterial infections of unknown etiology, Panalba offers excellent chances for therapeutic success—and why it should be your antibiotic of *first* resort.

The incidence of postoperative wound infections, particularly among debilitated patients, presents a serious hospital problem.[1] These infections are caused in many cases by strains of staphylococci resistant to most antibiotics in common use.[1,2,3] In such instances, CHLOROMYCETIN should be considered, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."[4]

Staphylococcal resistance to CHLOROMYCETIN remains surprisingly infrequent, despite widespread use of the drug.[2,4,5-7] In one hospital, for example, even though consumption of CHLOROMYCETIN increased markedly since 1955, there was little change in the susceptibility of staphylococci to the drug.[7]

Characteristically wide in its antibacterial spectrum, CHLOROMYCETIN has also proved valuable in surgical infections caused by other pathogens—both gram-positive **and** gram-negative.[7,8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Lancet* **1**:356, 1959.

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when postoperative infection complicates convalescence...

CHLOROMYCETIN®

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for broad antibacterial action





"Fear is sharpsighted..."

and has excellent ears as well. Witness the apprehensive cardiac who can hear his own heartbeat in the noisiest surroundings—the primigravida who experiences birth pangs six months ahead—the surgical patient who sees doom in the frown of a nurse.

It is in highly tense and anxious patients such as these that the "Librium Effect" shows up most distinctly. What is the Librium Effect? It's difficult to describe, but a patient treated with Librium feels different, even after a few doses. He appears different to his family and to his physician. Different not only in the sense of a change from the previous state of anxiety and tension, but also from the effect created by daytime sedatives or tranquilizers. Of very practical importance, too, is the fact that Librium does not depress the anxious patient and hence may be used safely even in the presence of depression. If you have patients whose "fear-sharpened" senses are making them—and those about them—miserable, why not investigate the "Librium Effect" for yourself? Consult literature and dosage information, available on request, before prescribing.

FOR RELIEF OF ANXIETY AND TENSION

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THE SUCCESSOR TO THE TRANQUILIZERS

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The Journal of The SOUTH CAROLINA Medical Association

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. . . even though surrounded by allergens. Co-Pyronil® provides smooth, continuous control of allergic symptoms—relief in minutes for hours, with virtually no side-effects. And there is a dosage form for every allergic patient.

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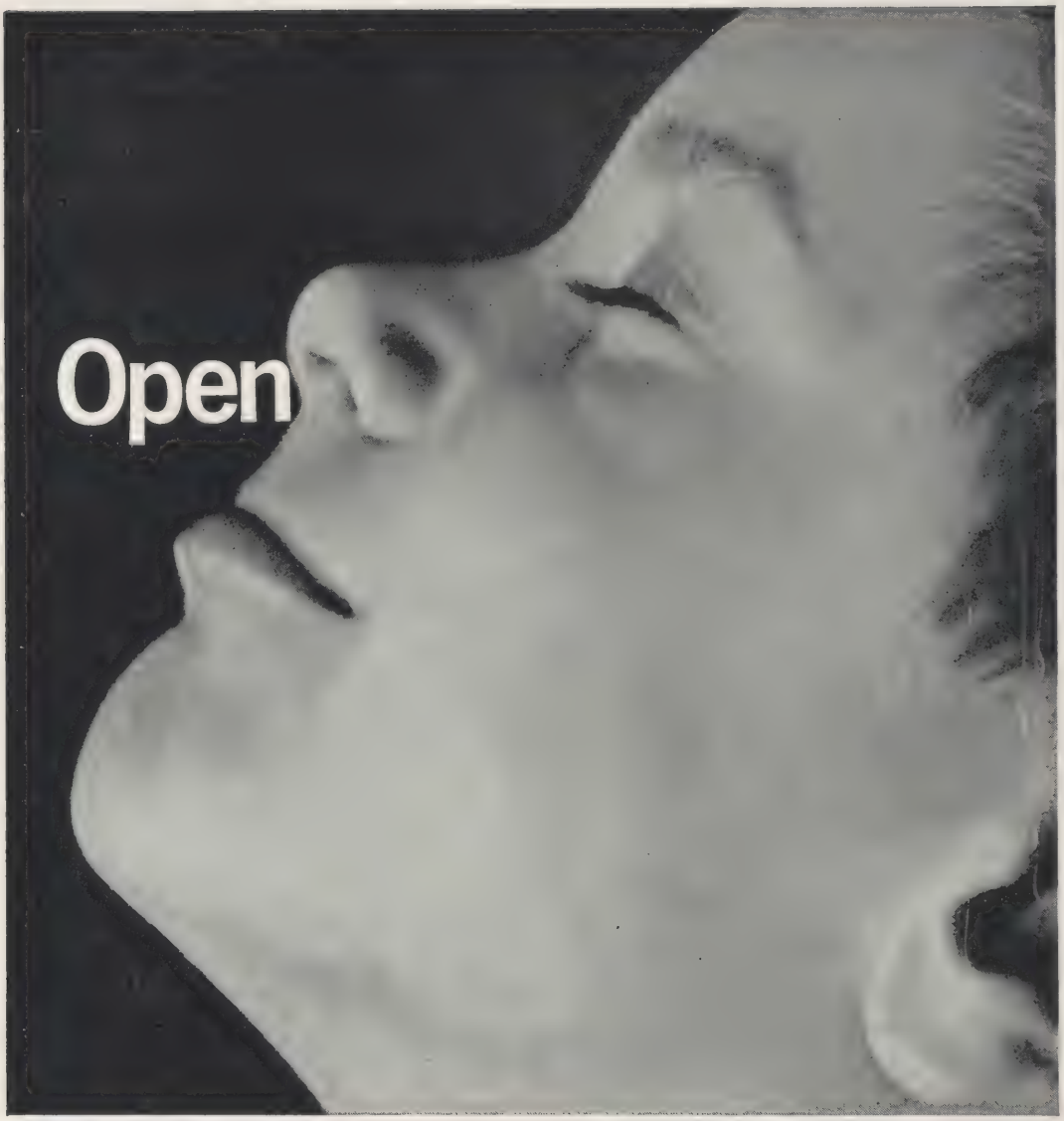
Co-Pyronil®
(pyrrobutamine compound, Lilly)

Each Pulvule contains Pyronil® (pyrrobutamine, Lilly), 15 mg.; Histadyl® (methapyrilene hydrochloride, Lilly), 25 mg.; and Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly), 12.5 mg. Each pediatric Pulvule or 5-cc. teaspoonful of the suspension contains half of the above quantities. This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

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INDEX MEDICUS



NTZ Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTZ is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCl 0.1% for potent topical antiallergic action; and Zephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas. NTZ is well tolerated and does not harm respiratory tissues.

NTZ Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

helps hay fever patients forget the "season"

NTZ® **Nasal Spray**

Winthrop LABORATORIES New York 18, N. Y.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran chloride (brand of benzalkonium chloride, refined)



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for the treatment of psychosomatic, neurotic and psychotic disorders and selected cases of alcoholism and drug addiction.

Psychotherapy, analytic or directive, individually or group oriented; electro-shock therapy; carbon dioxide inhalation; occupational therapy; medical and nursing regimens are carefully adapted to each patient's needs.

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A name that is not suggestive to your patient of therapeutic use



The first flavored sedative antispasmodic tablet that can be CHEWED SWALLOWED or allowed to DISSOLVE in the mouth.

EACH SCORED, MINT-FLAVORED TABLET CONTAINS:

Phenobarbital (Barbituric Acid Deriv.)	20.0 Mg.
WARNING: MAY BE HABIT FORMING	
Hyoscyamine Hydrobromide	0.134 Mg.
Hyoscine Hydrobromide	0.0081 Mg.
Atropine Sulfate	0.02 Mg.

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JONES AND VAUGHAN, INC., Richmond 26, Va.

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AUGUST, 1962 — VOL. 58, NO. 8

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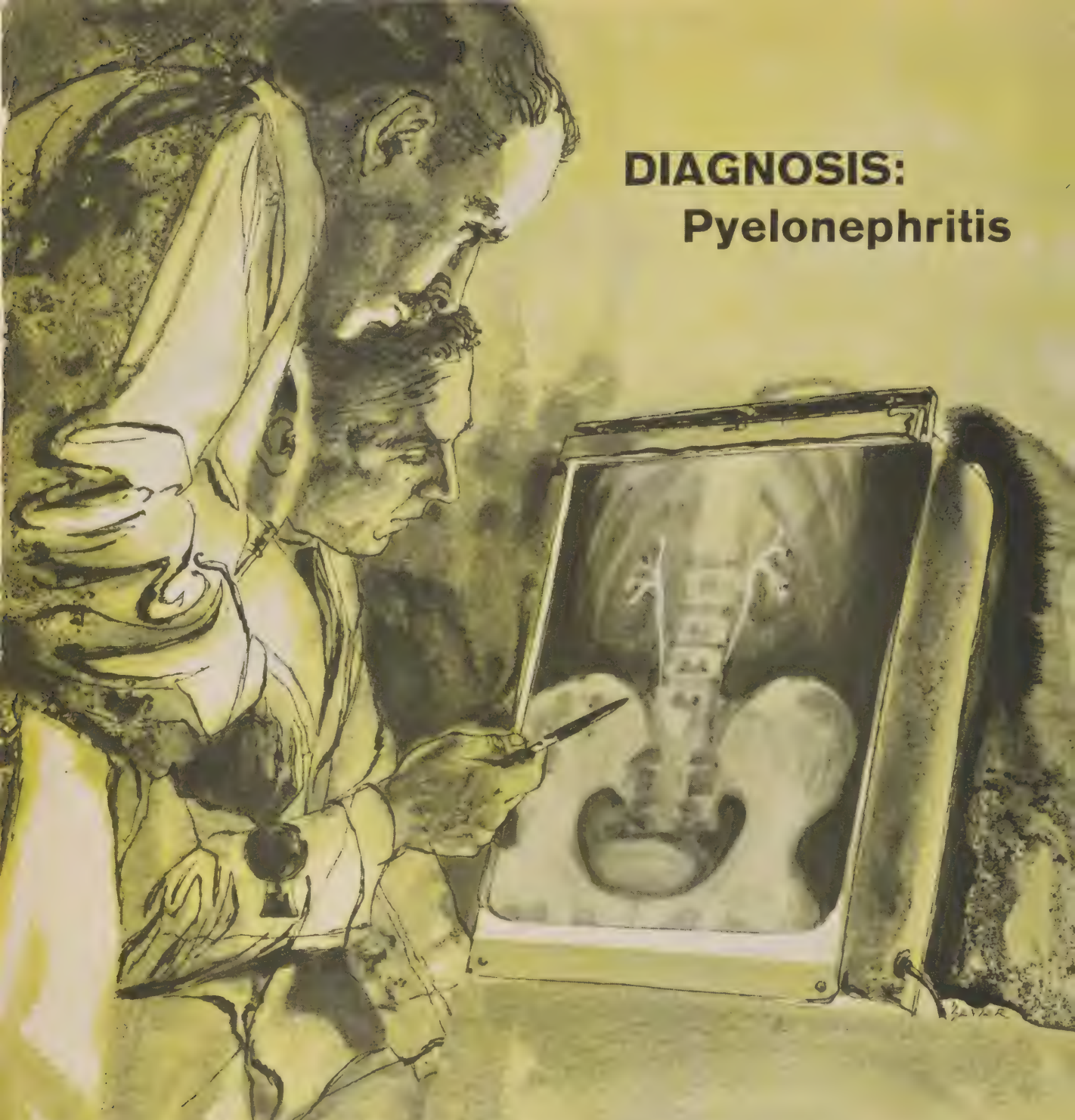
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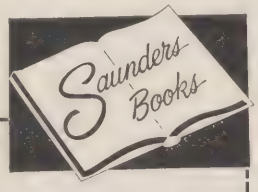
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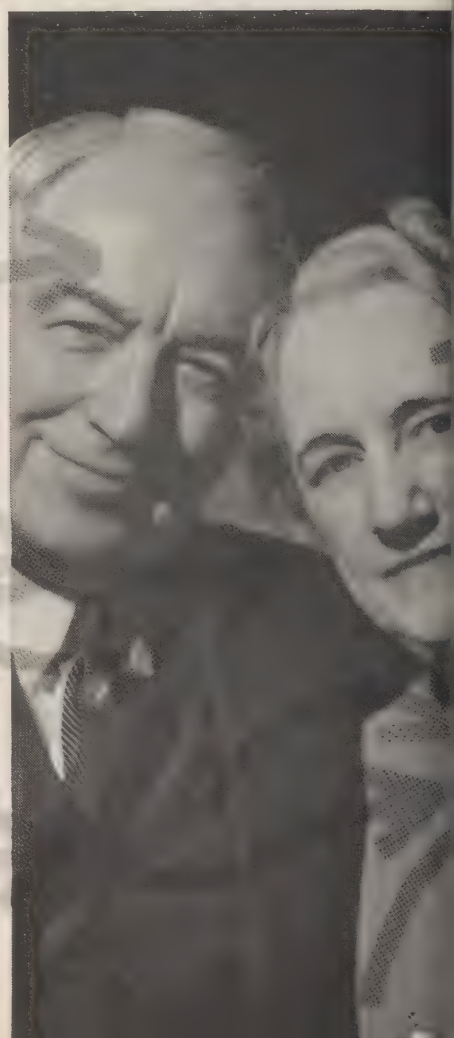


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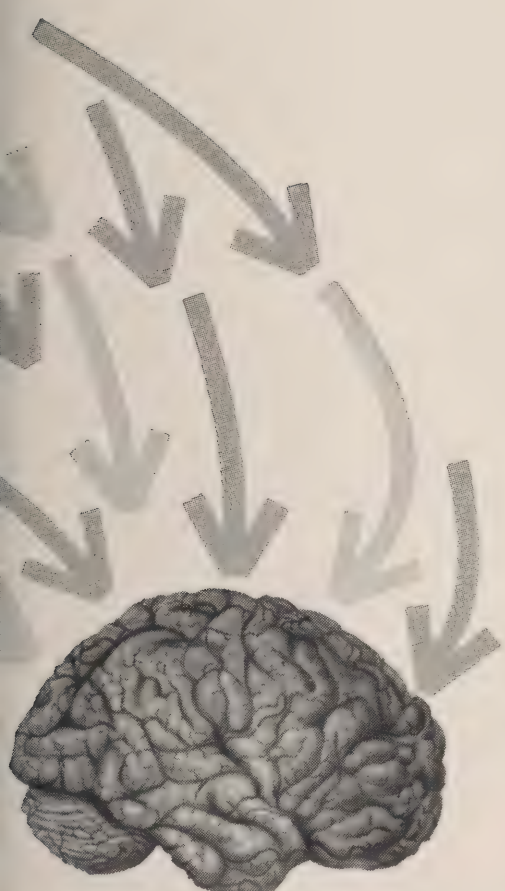
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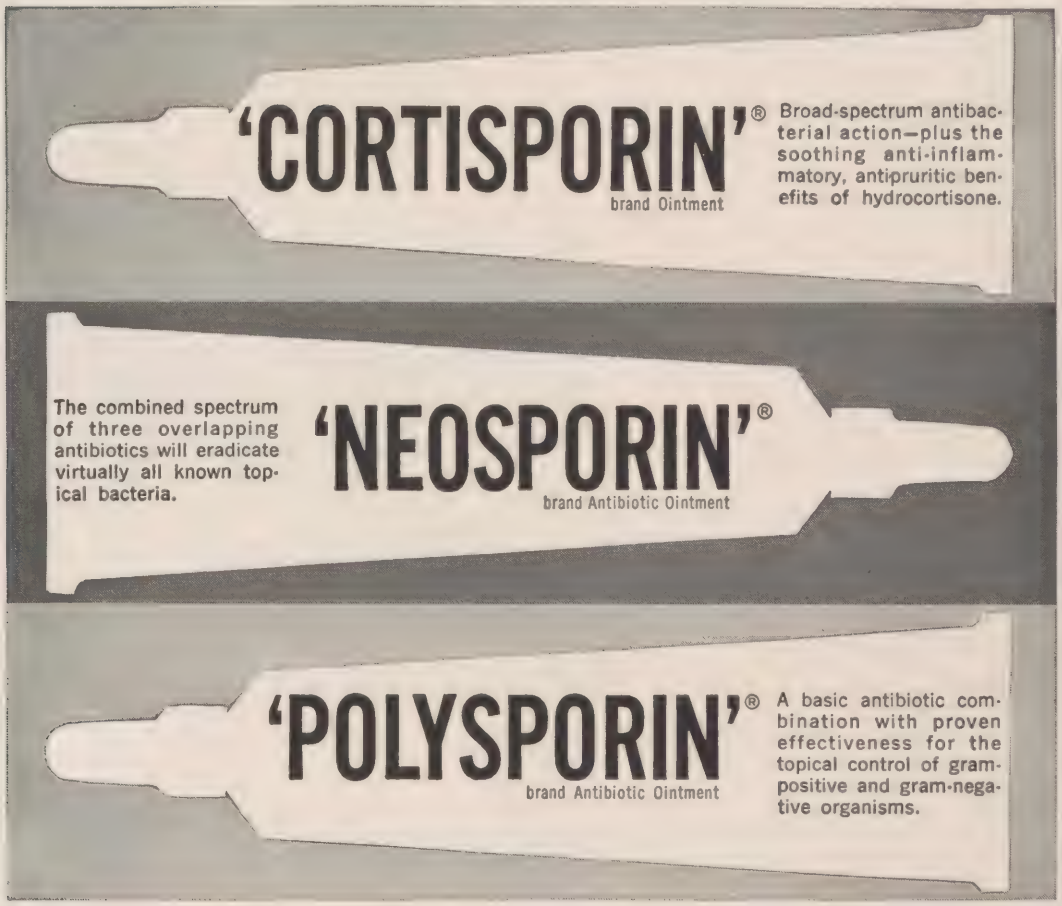
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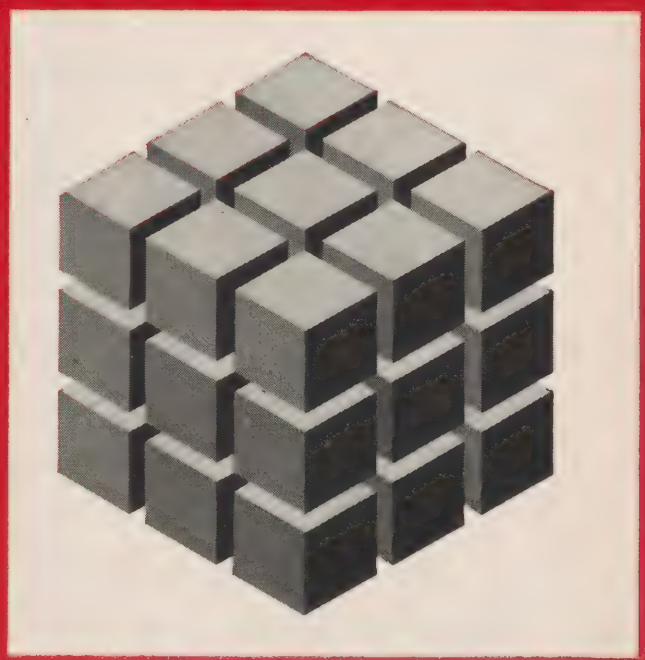
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GUIDES TO THE SAFE USE OF BLOOD TRANSFUSION THERAPY.

(PART) I.

PROPERTIES OF STORED BLOOD AND TECHNICAL CONSIDERATIONS IN TRANSFUSION THERAPY.

HARRY B. GREGORIE, JR., M. D.

Instructor in Surgery, Medical College of South Carolina
Charleston, South Carolina

Introduction

It is the purpose of this presentation to discuss the properties of blood for transfusion, and the techniques, indications, and complications concerning transfusion of blood. The extensiveness of the topic requires presentation of the material in a series of articles which will appear subsequently in this journal. This initial report involves a discussion of the properties of blood used for transfusion, and a consideration of technical factors important in safe transfusion therapy. Improvements in the collection and storage of blood and the application of the knowledge of immunologic factors have provided the clinician an invaluable tool. There are risks involved and the improper use of transfusion therapy entails a threat to the recipient which must be acknowledged. Crosby[5] has appropriately evaluated these considerations and has said: "Thoughtless prescription of blood transfusion is playing Russian roulette with bottles of blood instead of a revolver. While the odds are in the physician's favor that nothing will go wrong, the patient takes the risk."

History

There is uncertainty as to who performed the first blood transfusion.[1, 3, 4, 7, 9, 10, 11] Francisco Folli is said to have used a system of cannulas for the direct transfer of blood between humans at Florence, Italy in 1654. At Oxford University in 1165, Richard Lower documented the use of blood transfusions in dogs. In 1667, Denys and Emmerez of France administered sheeps blood to a human. Their first three patients survived, but the fourth died. A century later, James Blundell, an English obstetrician employed a syringe transfer method using human blood to combat postpartum hemorrhage. Because of air embolism, incompatibility reaction, infection, clotting difficulties, and phlebitis, his mortality rate was 50% in ten patients.

Probably the most important contributor to the development of blood transfusion therapy was Karl Landsteiner. In 1900, he discovered the blood types A, B, and O. In 1902, Jansky

confirmed Landsteiner's work as did Moss in 1910. Landsteiner later described the M and N factors, cold agglutinins, and finally he and Weiner discovered the Rh factors in 1940. Ottenberg is credited with the first large scale use of blood typing in selecting donors. He and Epstein devised a slide method for detecting incompatible mixtures in 1908.[11]

Lower recognized the difficulties caused by coagulation and used defibrinated blood in his animal experiments. Sodium oxalate was used by Arthrus and Pages to avoid in vitro clotting. Lewisohn and Weil established the sodium citrate procedure to avoid coagulation in 1915. ACD or acid-citrate-dextrose solution, as generally used today, was reported by Rapaport in 1947.

Further developments related to transfusion therapy are continuing at an important pace. New factors are being evaluated. Transfusion of portions or fractions of whole blood are being approached as a more specific type of therapy. Improved storage methods are being sought. Facilities for improving the safety and convenience of transfusion therapy are growing. The potential life-saving property of blood transfusions ranks high among the advances in medicine.

General Properties of Blood

Normal whole blood is a complex substance which may be considered as consisting of the formed elements (red cells, white cells, and platelets) suspended in a liquid medium (plasma). The properties of blood once removed from the donor undergo important changes.

Red Blood Cells. The red blood cells tend to hemolyze. This is increased by mechanical handling, storage at adverse temperatures, (best preserved 4° - 6° C), mixture with anti-coagulant solution (best preserved with ACD solution) and prolonged storage. Potassium leaves the cells while sodium enters. LeVeen[8] implicated potassium intoxication induced by rapid infusion of large quantities of bank blood to be the only apparent cause of cardiac arrest among 50 patients from a series of 157 cases of cardiac arrest. It is well known that potassium levels may reach 20 milliequivalents per liter in blood stored for three weeks. Fresh blood is therefore preferable for patients requiring massive transfusion. LeVeen suggests the use of ion-exchange resins to diminish potassium concentration and the use of digitalis to antagonize potassium intoxication. In cases in which a cardiac stimulant is required, rather than epinephrine, he suggests the use of isopropylarterenol (Isuprel) which has practically no influence on the liberation of potassium from the liver. Arbitrarily if 70% of the red blood cells removed from the donor assume normal function in the recipient, the stored blood is considered satisfactory for transfusion.[13] Red cell life span studies show that defective red blood cells following transfusion are largely eliminated 24 hours following transfusion, while 1% of the remainder are lost per day. Using ACD anti-coagulant solution and 4° to 6° C. storage temperatures, virtually all red blood cells retain normal function 10 to 15 days after withdrawal. At 21 days 90% are functional and at 28 days about 65%. Proper refrigeration until immediately ready for use is mandatory for such preservation. Walter *et al*[12] studied the properties of plastic storage containers for a period of 4 years. Their findings indicated the superiority of ACD blood stored in plastic bags over ACD blood stored in glass bottles, and also a higher degree of uniformity of performance to be expected in routine blood bank use of the former.

A two bag plastic equipment set has been described by Gibson[6] which serves to separate red cells and plasma by either settling or centrifugation and the use of a spring-activated press. Post-infusion survival by the radiochromium method showed the red cell survival to be a mean of 84% after 21 days storage. This survival rate equals that of cells stored in plastic bags as whole blood. The equipment is inexpensive, can be used in any standard blood bank, and permits the use of red cell suspensions when needed while at the same time augmenting the plasma bank inventory.

White Blood Cells. By employing isotope-tagging and cross circulation determinations

the life span of white blood cells has been estimated to be between 8 and 24 hours in donor blood. Phagocytic activity is lost in about 8 hours. After two to three days most of the granulocytes have degenerated. Transfusions to provide these components are of doubtful benefit.

Platelets. The life span determination of platelets is also difficult. After three days storage about 30% are still demonstrable although probably they are not viable. If blood is placed in ordinary glass containers and used in less than 4 hours, close to the theoretical quantities of platelets withdrawn are provided to the recipient. Benefits of such transfusions are doubtful. Platelets are probably harmed by contact with glass and citrate ion.

Plasma. Changes in the plasma in vitro are slight except for some of the coagulation factors. Albumin and globulin fractions of separated liquid plasma stored at room temperature remain stable for three years. After administration, albumin leaves the circulation to the extent of 50% in one day and an additional 30% by 6 days. Gamma globulin leaves the circulation to the extent of 50% in 14 days. In vitro fibrinogen content slowly decreases and fibrin deposits develop. Small clots in the donor bottle of blood may also develop from inadequate mixing of the blood and ACD solution at the time of collection. It is therefore imperative to filter blood or plasma when giving these to the patient to avoid embolic complications.

The matters of high plasma iso-agglutinin levels and homologous serum jaundice threaten the safe use of plasma transfusions. Fibrinogen and anti-hemophilic globulin may also transmit the latter. By pooling plasma from usually 300 to 400 donors a high iso-agglutinin level from any one donor is minimized by virtue of dilution in the pool. The problem of homologous serum jaundice has been approached by J. Garrott Allen[1] by employing prolonged storage of the plasma preparation at room temperature. Such storage also allows deterioration of iso-agglutinins. Viruses perish rapidly if kept at room temperature, whereas, most are resistant to cold and are preserved by the freezing and lyophile process which were used to preserve plasma during World War II. Allen demonstrated that 6 months storage of plasma at a mean temperature of 31.6°C. produced a pooled plasma essentially free from the risk of transmitting serum hepatitis.

Practical Considerations In Transfusion

Techniques

There are many factors which contribute to the dangers of blood transfusion. Major incompatibility reactions are chiefly due to improper identification of the donor and recipient. Multiple puncture holes in the bottle of blood suggest difficulty at the time of donation. The possibility of bacterial contamination in such bottles is increased. Clots may be seen in the bottle. If the clots are large enough to interfere with the administration, the bottle should be rejected. If the clots have developed during storage, this may indicate bacterial contamination as some bacteria metabolize citrate. Such blood should be discarded. Undue hemolysis or changes in the color of the blood are suggestive of bacterial contamination.

Refrigerated blood is often allowed to warm or is deliberately warmed to body temperature before transfusion. This practice should be avoided except when massive transfusions are to be employed and secondary hypothermia may result or except at times when the blood is to be used in a cardio-pulmonary perfusion apparatus. Selective cardiac hypothermia during massive transfusion may lead to cardiac arrest. If over-heated, denaturation of the blood results. When administered by the ordinary drip rate, blood tends to approach room temperature as it moves through the intravenous set. Further warming may be harmful to the blood and except for the specific allowances mentioned, rapid infusion of cold blood is well tolerated by the patient.

Ordinary elective transfusion flow rate has been arbitrarily set at about 2-4 ml. per minute. This means about 2 to 4 hours for a 500 ml. transfusion. Most major transfusion reactions may be detected after the administration of 50 ml. The flow rate during the first 50 ml. should therefore be slow. If no reaction

appears, the rate may be increased according to the patient's need and convenience, if the patient's cardiac and pulmonary status does not make rapid flow a potential danger. In certain instances, as in acute continuing blood volume deficit with hemorrhage, more rapid rates are mandatory. For such emergencies 100 ml. or more per minute may be pumped in. When pumping blood in under pressure, care must be taken to avoid allowing air to enter under pressure when the bottle empties. Fatalities from air embolism may result. Another problem during pressure infusion concerns fibrin clots which may be forced through the filter and cause embolic effects. The filter occasionally becomes coated with fibrin so that the blood level inside the filter is below the blood level outside. Air becomes trapped in the blood passing through the filter. The tube leading to the patient is then filled with minute air bubbles. If this is allowed to continue a considerable volume of air may enter. The filter should be changed.[3] Other sources of air emboli are leakage about an improperly secured cannula or polyethylene tube, large needle punctures in the tubing of the intravenous set, and ingress of air through a large needle during set changes. The intravenous drip set should be changed every six hours to minimize the threat of bacterial growth in the set.

The practice of injecting drugs into the blood bottle or infusion set is to be condemned. Calcium salts in particular may cause coagulation of the blood. Low pH vitamin preparations may denature the blood and cause reaction. Care should be taken to remove the antiseptic solution used to cleanse the bottle top (with a sterile dry wipe) during preparation of the bottle at the start of the transfusion so as to avoid the introduction of the antiseptic solution into the bottle. Y-tube administration sets are commonly used wherein a crystalloid solution is fed to one arm of the Y and the bottle to the other. This is a safe practice if incompatible agents are not administered. When 5% dextrose in water is mixed with blood, discreet small globules of blood are noted. This is termed pseudo-agglutination and is seemingly of little importance.[13]

When different blood groups are administered to a patient as an emergency measure, the exchange set should be changed each time the donor group changes.

The intra-arterial administration of blood has been said to be superior to the intravenous administration at times because of: (1) a greater and prompter increase in coronary and cerebral blood flow, (2) an instantaneous blood pressure increase due to hydrostatic effects, (3) the blood can be given faster by the intra-arterial route, and (4) intravenous blood tends to pool whereas intra-arterial blood is mixed and dispersed. This is not altogether true. Artz[2] points out that experiments by Kohlsteadt, Page, and Case have shown that arterial and coronary pressure response to transfusion was the same regardless of route in oligemic dogs and that the response was just as rapid intravenously as intra-arterially. The instantaneous "hydrostatic rise" of blood pressure from the intra-arterial route has been shown to be no different from the response to intravenous administration when measured by dye studies of cardiac output. The rate of administration of blood is a function of pressure in the blood bottle and tube, the resistance in the recipient vessel, needle, and tube, and the viscosity of the blood. Blood can actually be given more rapidly intravenously if appropriate vessels are employed. Precipitation of heart failure by administering blood intravenously usually occurs only after the blood pressure is returned to normal and in the face of underlying heart disease. As regards "pooling of intravenous blood" the intravenous administration actually restores the blood flow to collapsed vessels, as the flow to and thence from the heart per minute is many times greater than the volume which can be forced into the arterial circulation by direct intra-arterial administration. Intra-arterial transfusion is at times indicated when there is cardiac asystole and the left heart stops pumping, as there is no way for blood to reach the vessels. In such instances, it may be necessary to employ intra-arterial transfusion in con-

junction with appropriate cardiac massage and resuscitation. In mitral stenosis it may become desirable to avoid over-loading the right side of the heart and in such cases, intra-arterial transfusion would be preferable. Intra-arterial transfusion may produce necrosis and gangrene because of secondary arteriospasm.

Summary

1. A brief survey of historical developments in blood transfusion therapy has been outlined.

2. The properties of stored blood are discussed. Aging chiefly produces red cell hemolysis and increased available potassium. Virtually normal function of red cells is retained in ACD storage at 4° C. for 15 days.

3. Methods for improving blood storage are mentioned.

4. Properties and storage methods of plasma have been outlined.

5. Technical considerations in the safe performance of transfusion therapy are discussed. Important factors to be considered in inspection of the blood are listed. Warming of blood prior to administration is to be avoided except in massive transfusions. Flow rates of 2-4 ml. per minute are used for elective transfusions. For emergency transfusions, rates of 100 ml. or more per minute may be required. Factors leading to air embolism are mentioned. Injection of drugs into the blood bottle is inadvisable and dangerous.

6. Benefits and dangers of intra-arterial versus intra-venous routes of administration are cited.

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OF APPLES AND GERMS

REPORT No. 1, from *Science News Letter*: "The maxim, 'An apple a day keeps the doctor away,' has been confirmed by more than 1,300 volunteer students at Michigan State University. In the three-year study, health records showed significantly fewer calls to the university's health center by the apple-eating students than from others. Investigators said vitamin C in the apples have accounted for the benefit, and that perhaps some naturally occurring tranquilizer in the apple accounted for lessening tension-pressure."

EPIDEMIOLOGICAL MANIFESTATIONS OF THE PHYSIOLOGICAL ASPECTS OF CORONARY HEART DISEASE

A CONDENSED ANALYSIS OF THE SIX-YEAR FOLLOW-UP IN THE FRAMINGHAM STUDY

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The Framingham Study

In the Framingham Study* there are two tables with which we are concerned in this presentation. They are Tables 3 & 4 (p. 37) of the Six Year Follow-up. All other tables in this report are naturally concerned with the variables under study, but Table 3 & 4 give an overall picture of the state of health —coronary heart disease over the six-year period.

Table 3
Six-year incidence rate of new coronary heart disease by age and sex

Age at entry	*Rate per 1,000 Population*
Men	54.8
30-44 Yrs.	24.9
45-62 Yrs.	90.6
Women	21.4
30-44 Yrs.	1.9
45-62 Yrs.	44.6

A quick look at part of Table 3 will suffice to show us the rate of development of new coronary heart disease in the Framingham Study in 6 years. Men developed this disease at the rate of 54.8 per 1000 over the 6 year period and women at the rate of 21.4 per 1000. As usual, the rate is higher for males than for females, and higher in the older age group for both sexes.

In actual cases this means that 186 persons in the population at risk who were free of coronary heart disease 6 years ago now have (or had) coronary heart disease—125 of them men and 61 women, as will be seen in Table 4. This represents an overall 6-year incidence of 36.4 per 1000.

While the overall rate broken down by sex is weighted 2.5 to 1 on the male side, the contrast is even more striking between the two age groups. In the younger age-group (30-44 yrs.) there was an incidence of 1.9 per 1000 in women as compared with 24.9 per 1000 in men—a 13-fold difference. In the older age-group (45-61 yrs.) this sex ratio drops to only a two-fold difference, with an incidence of 90.6 per 1000 in men and 44.6 per 1000 in women.

*The Heart Disease Epidemiology Study. Framingham, Mass. by The National Heart Institute. A 20 year study begun in 1948.

Table 4
Clinical manifestations of coronary heart disease developing in 6 years of follow-up

Clinical Manifestation	*Number*		*Per Cent*	
	Men	*Women*	*Men*	*Women*
Total coronary disease	125	61	100.0	100.0
Definite myocardial infarction by history and ECG	57	14	45.6	23.0
With angina	32	7		
Without angina	25	7		
Definite myocardial infarction by ECG only	7	2	5.6	3.3
Sudden death	24	3	19.2	4.9
With pre-existing infarction	3	--		
With pre-existing angina	6	--		
Without pre-existing coronary disease	15	3		
Definite angina pectoris	37	42	29.6	68.8

Now let's contrast the age-groups within the sexes. In men the older age-group had 3.6 times as much coronary heart disease as the younger group, and in women the older age-group had 24 times as much as the younger group.

Now we look at Table 4. We are concerned here with the criteria for measuring coronary heart disease as generally set out, viz. angina pectoris, myocardial infarction and sudden death. In this study all cases of sudden death, not definitely attributable to other causes, were considered to be due to myocardial infarction.

Angina pectoris

Seventy-five men (60%) and 49 women (80%) were known to have angina pectoris either alone or in connection with myocardial infarction. Of the 57 men with clinical infarction 32, or 56% of them, had pre-existing angina. Of the sudden deaths assigned to infarction 6, or 25% of them had pre-existing angina. These figures are impressive enough to suggest that the 37 men and possibly the 42 women with angina alone had better have their houses in order. It is evident, however, that coronary disease in women may take, chiefly, the form of angina in about 70% of the cases. If all cases of angina occurring in a community are considered, instead of just those who consult physicians, angina is almost as common in females as in males. Forty percent of all angina in the study occurred in females.

Picking out the angina cases we see, among males, 32 cases involved in infarction and 6 involved in sudden death, for a total of 38 cases in which angina is a part of another syndrome, as against the 37 cases of definite, uncomplicated angina. The relationship is about 50-50. But look at the females. There are 7 cases of angina involved in infarction as against 42 cases not so involved. The relationship here is 14 to 86 (by percentage). Thus we see another indication that maybe angina is more lethal in men, or at any rate more apt to be associated with serious heart conditions.

Myocardial infarction

More striking are the figures on infarction. Eighty-eight men and 19 women developed this condition in the six-year follow-up. More striking still, is the fact that 24 men and 3 women died suddenly of the condition and—worse yet—15 of the men and all of the women were struck down by it without any known warning.

Seven men and 2 women in Framingham now know they have developed infarction within the past 6 years simply because they have had routine ECG's as a part of the study.

In studying the physiological characteristics of coronary disease we ran across some other interesting observations in the current literature.

Brachfeld and Gorlin[1] attempt to apply physiological principles to the study of the hemodynamic status and functional adequacy of the coronary circulation. They conclude that the ability of the coronary circulation to dilate under challenge is necessary before one can be classed as free of coronary disease. (Two surgical methods of treatment: (1) Epicardial phenolization along with poudrage and cardiopneumopexy and (2) Bilateral ligation of the internal mammary arteries, were condemned as ineffective.)

Agar[2] reported on 1000 patients with coronary artery disease in his private practice in Australia over a 10-year period in a surrounding population of 100,000.

There were 324 deaths, or a mortality rate of 32.4% in his 1000 patients, but these 324 were 23% of all the deaths from coronary disease in the 100,000 population of Geelong. In this study office workers appeared in a ratio of 3 to 2 over manual workers, though he included housewives in the manual workers. Males accounted for 66% of the cases and 71% of the deaths, from which he deduced that coronary disease is not only more frequent in males, but also more lethal. Most of his patients (64.4%) were between 50 and 70 years of age, and 97.6% were over 40. Seventy-one percent had infarcts, 15% of which were "silent". Four hundred and one patients were found (at time of examination) to have pre-

viously existing myocardial ischemia or infarction, but 113 were discovered as new cases. Six percent of these patients were first diagnosed as congestive heart failure. but ECG revealed a previous painless infarction. Thirty percent reported that their pain was not related to exertion but of the 70 percent who noted a relationship, most of them said the pain followed, rather than accompanied exertion. Several cases followed severe emotional or mental stress.

Dr. Agar evidently does a routine electrocardiogram on his diabetic patients, and picked up 1.5% of his cases of coronary disease in that way. Four patients had their disease precipitated by post-operative hypotension.

In 626 patients—61% of them males—angina was the presenting symptom.

Diseases associated with coronary disease were: hypertension, obesity, diabetes, gallbladder disease, cerebral vascular accidents and pneumonia. Only diabetes and cerebral vascular accidents affect the mortality adversely, and that in the older age group. Only 17% of obese patients died of their coronary disease, but further analysis showed they were mostly in the younger age groups and that factor of protection seemed to be stronger than the obesity factor of detriment.

Vakil[3] comes up with a fairly new (to this study) classification of coronary heart disease as he introduces the concept of the *intermediate coronary syndrome*. This, he says, should be accepted as a separate entity between angina and infarction. It has long been recognized by such vague names as "advanced angina", "atypical angina", "premonitory phase of angina", "ambulatory infarction", but his studies lead him to believe it should be given a rank of its own in the diagnosis of coronary heart disease. He presents 251 cases, 216 of them males and 35 females. He proceeds to classify the 216 males according to occupation:

1. Executives	49
2. Professions (e.g. doctors)	57
3. Semi-professions (e.g. technicians)	20
4. Skilled workers (e.g. army)	41
5. Semi-skilled workers (e.g. mechanics)	30
6. Unskilled workers (e.g. millworkers)	16
7. Unemployed	3

Then he goes on to list the important pre-existing diseases with their incidence, suggesting they may be etiologic factors.

Incidence of important pre-existing diseases in 251 cases of intermediate coronary syndrome

Etiologic Factor?	Percent
1. Angina pectoris	50.4
2. Hypertension	36.8
3. Obesity	28.4
4. Diabetes mellitus	13.6
5. Coronary occlusion	5.2
6. Gallbladder disease	4.0
7. Family history (in 182 cases)	22.0
(Note: in 200 normal controls)	6.0

Dawber and Kannel,[4] again assert their belief that CHD becomes manifest as 3 major clinical entities: sudden, unexpected death, myocardial infarction and angina pectoris, and add that most sudden deaths in adult populations are due to disease of the coronary artery. In fact, approximately 16% of all coronary heart disease is manifested by sudden death. The percentage is even higher when we consider the male population only. A program of prevention, if available, they state, is the only aid we can offer a very large number of people.

The deaths known to be due to myocardial infarction plus the sudden deaths account for 40% of the total mortality from coronary heart disease.

Conclusion

Angina pectoris indicates an inadequate coronary blood flow. This is probably due to advanced atherosclerosis. It is the only form of coronary heart disease that can be diagnosed before actual changes take place in the heart muscle. If the process can be found to be reversible it will afford a considerable group of salvagable patients. However it is not infrequent for angina pectoris to indicate an already existing myocardial infarction.

We need a program of prevention that will be effective many years before the first recognizable symptom of coronary heart disease could be detected.

(See References—Page 317)

THE PHYSICIAN, THE PSYCHE AND HYPERTENSION TODAY

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We do not know what causes primary arterial or "essential" hypertension; yet we are confronted with an array of hypotheses and theories and suggestive evidence that would fill libraries. As physicians faced with the task of treating the patient with hypertension of unknown etiology we are dealing with something of a dilemma. We cannot remove a cause which is nebulous yet we are obligated to prolong our patient's life and to make it as comfortable as possible. The solution is not difficult when one recognizes an often forgotten but fundamental rule of the art of medicine—treat the whole patient: with this thought in mind, I should like to approach the treatment of this topic.

Psychiatrists and internists have reproached one another for methods used in seeking the etiology of essential hypertension and treating it. Physicians of all disciplines must profit by the example of Aesop's six blind men and the passing elephant—they must lay their hands on it from the particular vantage point that is theirs and by comparing results and trying out hypotheses try to explain the discrepancies in their observations.

Some internists have suggested that hypertension is due to a hereditary factor to which some non-specific toxic, psychic or mechanical factors are added to produce the final result. There is very good evidence for this view, particularly the frequent occurrence of hypertension in certain families, the evidences of predisposition to hypertension in certain individuals who show the vasomotor hypersensitivity indicated by the Hines-Brown test.[1] It has been suggested that differences in incidence of hypertension in racial groups exist due to cultural differences of the races, and that culture being the same for different racial groups, occurrence of hypertension will be more nearly the same.

In a recent issue of *The Lancet* Cruz-Coke reported on his study of two subsamples of a homogeneous population in Peru, one being in rapid cultural transition from a primitive society to the stress of Western civilization. Results showed that only the group undergoing rapid cultural change had a rise of mean blood pressure. Comparison of a London population with a primitive population in the Andes matched for age and sex demonstrated that the primitive population had a significantly lower mean systolic blood pressure. It is suggested that while genetics may well play a part in accounting for these differences one nevertheless feels inclined to attribute the differences to environment.[2]

In their book *Life Stress and Essential Hypertension* Wolf and coauthors report observations on 114 predominantly white subjects. They were not impressed by a uniform personality pattern in their subjects as gleaned from life histories, attitudes and reactions, but there did appear to be a striking similarity in the way the patients looked at life, evaluated events, problems and challenges, and the manner in which they dealt with these things. Hypertensive persons were inclined to be tentative, and wary, fundamentally driving and often hostile but not able to fully commit or assert themselves. It is pointed out that these attitudes are neither unique nor exclusive to individuals with essential hypertension but that they were seen frequently enough to be familiar.[3]

In a study of emotional factors in essential hypertension Franz Alexander concludes "that the early fluctuating phase of essential hypertension is the manifestation of a psychoneurotic condition based on excessive and inhibited hostile impulses. As such it is a reaction of the individual to the complexities of

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our present civilization. Since the same psychological condition is extremely widespread and finds expression in different forms of neuroses, the question of specificity still requires further investigation. The assumption of a constitutional instability of the vasomotor system therefore cannot be discarded. It is to be hoped, however, that further psychological investigations on hypertension will make it possible to discriminate a specific neurotic handling of hostile impulses which necessarily leads to extreme fluctuations of the blood pressure and then secondarily to its later organic consequences."[4]

Otto Fenichel in his book *The Psychoanalytic Theory of Neuroses* sums up the results of other psychiatric work on persons with essential hypertension. Patients with essential hypertension are characterized by an extreme, unconscious instinctual tension, a general readiness for aggressiveness as well as a passive-receptive longing to get rid of the aggressiveness. These tendencies are apparently unconscious since they occur in persons who superficially seem to be very calm and permit themselves no outlets for their impulses. This unrealized inner tension seems to be one of the etiological components of essential hypertension.[5]

In studies of the emotional responses evoked by a stressful interview and of the relation between these and comcomitant cardiovascular changes it was found that subjects tending to suppress anger, rather than the reverse, had a higher diastolic and a lower systolic blood pressure at equal levels of anger. This same group was characterized by lower levels of anger consciously experienced, expressed by motor activity and of the total variety. Thus the general quality of constraint or inhibition of anger was associated with physiological differences consistent with an elevated peripheral resistance.[6]

Recently Shapiro observed that by employing four tests of noxious stimuli—both physical and psychic—he could demonstrate significant differences in blood pressure responses of normotensive and hypertensive individuals. He also observed that normotensive individuals with a family history of hypertension had enhanced responses to all tests. A psychological test revealed no significant differences between the groups with different responses to the noxious stimuli.[7] This same author has concluded in a review article of psychophysiologic mechanisms in hypertension that there is ample evidence that pathways exist for the physiological translation of emotions into blood pressure but suggests that it is unlikely that psychogenic disturbances are ever solely responsible for the development of hypertension.[8]

Ostfield and Lebovits have ranked seventeen Southern-born Negroes by systolic and diastolic blood pressure lability and by scores on the scales of a psychological test and found significant positive correlations in both populations between systolic and diastolic lability and certain scores in the test. The subjects whose blood pressure varied the most scored higher on measures of impulsive, hypochondrical, and hysterical behavior.[9]

Raiser, Weiner, and Thaler have recently reported that hypertensive patients "insulate" themselves emotionally in interpersonal relationships and suggest that this defensive operation may be a reflection of an inherited vascular hyperreactivity due to its restraining effect on actively expressed hostility rather than a direct pathogenic mechanism.[10]

Reiser and Bakst in a discussion of the psychology of cardiovascular disorders state that in the genesis of symptoms in the patient with essential hypertension a unique feedback cycle may be seen with some frequency. Symptoms occurring on the basis of purely psychologic mechanisms and symptoms arising on the basis of purely psychosomatic mechanism involving other body systems (for example, muscle-tension headache) may be regarded by the patient as evidence of progression or worsening of the basic hypertensive disorder. The anxiety evoked by these symptoms may then channel back through the basic hypertensive mechanism and lead to the very thing the patient feared—elevation of blood pressure and aggravation of the disease process.[11]

In a recent article in *The Lancet* Jan Brod

points out that if his data are correct (and they appear to be as nearly correct as possible with present methods and tools), then the rise of blood pressure in essential hypertension, at any rate in the early stages, can be explained by the hypertensive's more or less permanent readiness for muscular action. This explanation regards essential hypertension as the result of disturbed regulation of one of the fundamental haemodynamic responses of the patient. Using this hypothesis one is not surprised that the distinction between normal and hypertensive states is not sharp or that in early hypertension anatomical changes are not encountered anywhere in the body. It is yet to be demonstrated why regulation of this fundamental reaction is disturbed. When studying pressor responses repeatedly in the same person, Brod was struck by the way the course of a patient sometimes changed when the tests were carried out in adverse circumstances, such as when the patient was troubled by the illness of a relative or a recent quarrel with a colleague. "In the causation of essential hypertension, accumulation of adverse environmental factors—stress and traumatic events—has often been indicated; and we may reasonably suppose that if these factors are perpetually provoking haemodynamic reactions, the normalizing restorative mechanisms will eventually weaken, and the circulatory system will become continuously keyed to action. The fact that this is no more than an exaggeration of an ordinary physiological response explains why only an increase in blood pressure is induced and not some other functional disturbance. Differences in the capacity of the regulatory mechanisms to stand up to wear and tear would explain the familial prevalence of the disease."[12]

We do not yet know exactly where the regulatory mechanisms are disturbed, but several clues (electroencephalographic and pharmacological, for instance) point to the central nervous system. Before reaching any conclusions possible changes in the effector organ must be excluded—i.e., in the response of the smooth muscle of the blood vessels. Only when this question is settled, the role of renal and other pressor substances is clarified, and more understanding is gained of the metabolic aspects of hypertension can we hope for a solution of this part of our problem.[12]

Confronted with these statements and this evidence, what then are we as practitioners of medicine to do for our patients with essential hypertension? Certainly, we cannot do much to change the environment in which our patient lives. Changing the attitudes and habits of a lifetime is difficult and often impossible. And, obviously, once histopathological vascular changes are apparent one finds it difficult to change through mind what has already been accomplished in matter. Psychotherapy by itself has its greatest chance—if a chance at all—in the early fluctuating phase of hypertension. But, as in all disease processes, whatever the cause and effect, psychotherapy has a role in the treatment of persons with hypertension. Especially, the physician who should hope to deal successfully with hypertensive patients should not merely be a wielder of cold instruments and a dispenser of pills but also a pillow of comfort in times of trouble.

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Editorials

The English Language As Used In Medical Journals

It is not unusual at the present time for one to be well educated and well trained in the medical sciences, and yet know little or nothing of Greek or of Latin. Indeed the average graduate of a medical school today has not had more than one or two years of Latin and no Greek.

So unquestionably a knowledge of the so-called "dead languages" is not essential, but the matter of what is essential and desirable is very different.

As all of us know, the words used in anatomy are almost all Latin. This is not surprising, for Vesalius, to whom we are most indebted for our anatomical terms did most of his dissecting and writing in Padua, and naturally published his masterpiece, *"De Humani Corporis Fabrica"* or the structure of the human body, in 1543 in Latin. For at that time and for many years thereafter Latin was the language of science.

Even today medical students must learn the Latin names of the parts of the body. Undoubtedly a knowledge of that language makes the learning and the understanding of anatomy far easier.

Most will agree that anatomy is still the foundation of medicine. But when one comes to reading of diseases, Latin is of no value, for here Greek is used. This came about because Greek medicine became of much importance at the time of Hippocrates, who was born about 460 B. C. Then and for many centuries all diseases were described in the Greek language. Many writers of note in the ancient world made contributions to medicine, and of these some are of much value, even though not modern. Further lacking instruments of precision and the ancillary sciences of bio-chemistry, radiology, and others, all that they had were their powers of observation.

When Byzantium was captured by the Turks in 1453 A. D., many Greek scholars fled to Europe. Many went to Italy and a few to England.

Also at about this time Thomas Linacre (1460-1524) an Englishman who had studied Greek at Oxford, returned from Rome, Florence, and Padua, where he had been under Greek scholars. He settled in Oxford where he taught Greek and practiced medicine.

From the preceding it should not be difficult to understand why it is that so many words used in medical books or journals are in Greek or Latin or at least derived from those languages.

However, if one writes for a medical journal, aside from some knowledge of the ancient languages, there is much that he can do to clarify and rectify his phraseology. Some errors are serious and damaging. It is not unusual to find a verb in the singular used with a noun in the plural. One of the commonest mistakes is to place the Greek plural criteria where the singular, criterion, should be employed. Quite frequently the words phenomenon (singular) and phenomena (plural) are interchanged.

It is not unusual to find certain trite or hackneyed words or phrases which should not be present. This raises the question as to whether the writer is truly conveying the meaning intended. Further it is common to have a noun used where an adjective should be, or vice versa. Occasionally one reads that "no pathology was found," when the author intended to state that "nothing pathological was present."

Although it is not necessary for a medical author to take a course in grammar or syntax, yet it would not be amiss for him before beginning his contribution to read critically the writings of others and note the common mistakes made in the use of words and sentences. Or it might be well to read the writings of some medical authors. A few of their names quickly come to mind. Among them are Thomas Sydenham, Thomas Addison, Richard Bright, our own S. Weir Mitchell and Sir

William Osler who is claimed by Canada, the United States, and England.

In the fine literature whose authors are not or were not doctors, the story or the plot may not be of great importance to any of us, but the composition and skill in the use of language assuredly is. Notwithstanding all that has been said in the advocacy of the better use of English, it must be emphasized that for fear of betraying some linguistic disability, no one should refrain from putting on paper whatever worthwhile he has to say.

R. M. Pollitzer, M. D.

The Medical Technologist

The newest profession in the medical field is that of the Medical Technologist. Medical technology has come of age since World War II. It is one of the most important, fastest growing, and lucrative fields that youngsters of today could select for a career.

There is a growing need for well-trained technical workers of all kinds, according to a bulletin released this month by the Women's Bureau of the United States Department of Labor. A number of surveys indicate that more than three or four times the number of currently trained and practicing medical technologists are needed. There is already such a grave shortage of doctors, that their time must be conserved and extended by the aid of qualified medical technologists.

According to the National Council of Medical Technology Schools, a national group approved training institutions for this field. Salary opportunities are excellent—ranging from $300 to $700 a month, depending upon experience. Advances in rank and salary are usually rapid. Many youngsters, unable to afford the time and tuition to become physicians, first become medical technologists and then use their skills as a stepping stone to a full medical career.

The top independent medical technology schools last year graduated nearly 1,100 students. This year they are training nearly 1,300, but the demand for well-qualified graduates is outracing the supply more and more each year. By streamlining instruction methods in the usual 1500-hour program of instruction, these schools hope to close the gap.

With the increase in treatment facilities and the greater public awareness of the dangers of all diseases, doctors will need more and more "strong, right arms" to help them serve humanity. Here is a career that should appeal to every young person in the land who wants to equip himself for dedicated service, to earn good pay and be assured of ever-increasing job opportunities.

Miscellany

It is comforting to see that a poll of physicians in South Carolina indicates that only 2.5 percent favored the King-Anderson Bill, a much lower figure than the national one of 9.8 percent.

Doctors over the state have been doing their good part in explaining the situation about the government schemes to lay audiences. Dr. R. L. Skinner of Florence expounded the King-Anderson Bill on June 13 and many others have done similar good work in many areas.

Courses in Medical Self Help and Care of the Aged have been set up in a number of places over the state. One has been held at Wellford, another at Florence, and others in other areas within the near past.

Mental health provisions seem to be under some scrutiny, particularly by the Charleston County Medical Society, which has published a long report considering the subject. The Society feels that the present and more recent provisions are not proper from the standpoint of medicine. In the meantime a group of people in Winnsboro are exploring the possibility of establishing a mental health chapter in Fairfield and the South Carolina Mental Health Association has decided to employ an additional representative to begin work next January.

Those who wish to see the complete report on Mental Health legislation may obtain copies from Dr. F. M. Ball, 65 Gadsden Street, Charleston, S. C., or may find the report published serially in the *Scribe*, a publication of the Charleston County Medical Society.

Dr. Richard L. Jackson of Myrtle Beach presented a paper on "Chronic Regional Enteritis" at the recent meeting of the South Carolina Chapter of the College of Surgeons and the South Carolina Surgical Society.

York County has indicated its recognition of the need for more nursing homes by planning to build a thirty-bed home adjacent to the Divine Savior Hospital in York. Another home, including forty-two beds, is now under construction in Rock Hill. There is also an active effort on the part of those people who are concerned with nursing homes to raise the standards of care and to move toward proper accreditation of these important facilities.

Speaking of building, the South Carolina State Hospital is planning a three million dollar project which will be a Receiving and Intensive Treatment Center.

The South Carolina Public Health Association held a most successful convention at Myrtle Beach in June. Its membership now numbers 1,039, physicians, dentists, nurses, etc. Dr. Malcolm Dantzler of the Charleston County Health Department was installed as president for the current year.

Sweeping statements by the pundits that certain diseases are now extinct, such as poliomyelitis and diphtheria, are annoying to those who can read of the occurrence of such diseases at the present time. At least two cases of diphtheria have been reported in Greenville County right recently. Somebody, most likely the parents, failed to use the simple preventive measure.

The alarming resurgence of venereal disease among young people has been mentioned frequently in recent writings.

Orangeburg Regional Hospital has been the recipient of a legal suit aimed at accomplishing racial integration in the hospital. The case was dismissed.

Going back to the venereal disease question, unfortunately South Carolina stands second from the top in frequency of occurrence. On the other hand the state shows a very low incidence of active tuberculosis, being in the lowest bracket. This latter is a matter for pride and praise for those who have worked so hard to reduce tuberculosis.

Surgeon-General Terry of the Public Health Service, foreseeing another wave of Asian influenza for next winter, is urging that all pregnant women, all persons suffering chronic debilitating diseases and the general population over the age of forty-five be vaccinated before the threatened arrival of the infection.

Correspondence

Dear Dr. Waring:

I shall appreciate it if you will publish a notice in *The Journal* asking anyone who has suggestions or complaints regarding the actions and functions of the Department of Public Welfare in relation to medical practice to mail these suggestions or questions to me.

Yours very truly,
V. Wells Brabham, Jr., M. D.
Chairman Liaison Committee
Orangeburg, S. C.

June 7, 1962
In Reply Refer To: 3043/25

Gentlemen:

We have several vacancies for Staff Psychiatrist and we are hopeful that your organization might be of assistance in referring the names of qualified candidates to us. We are interested in considering either male or female applicants.

We will appreciate any assistance you may be able to provide, both in publicizing our needs in your own publication, or in other appropriate media and in referring candidates.

Very truly yours,
HARRY LEEB, M. D. Director, Outpatient Clinic
Veterans Administration Regional Office
49 Fourth Street San Francisco 3, California

S. C. DOCTORS MAKE NEWS
Speeches Against King-Anderson Gain Favorable Press

Physicians from all parts of the state have been making concerted individual and collective efforts to inform the public of the true contents of the King-Anderson Bill.

S. C. newspapers, whose news of the medical community was once restricted largely to conventions, new hospitals, doctors honored, and obituaries, are now full of doctors "speaking out" against Kennedy's care for the aged under social security. A brief review of the state's newspapers yields the following stories—and the list is by no means complete.

The Greenville Piedmont

Barr Describes English System

Dr. James S. Barr, an anesthesiologist from Perth, Scotland, now practicing in Greenville, painted a bleak picture of England's socialistic national health service last night at a joint meeting of the Greenville County Medical Society and the Greenville Lawyers' Club.

Dr. Barr explained results of the system such as three-year waiting lists in hospitals for people who have no urgent medical needs, doctors' being subject to coercion by patients, and the declining quality of applicants at medical schools.

The doctor said that although there were many complaints about the system, he thought that it would now be impossible to rescind it.

The Herald Advocate, Bennettsville

Rotarians Hear Discussion of Medicare Plan

Bennettsville Rotarians heard a Florence attorney explain the contents of the King-Anderson (Medicare) Bill, now pending before the Congress at their Tuesday luncheon meeting at Farron's.

JACK MEADORS of Florence, executive secretary and legal representative of the South Carolina Medical Association, addressed the group on this legislation, explaining its contents and possible implications.

The News and Courier, Charleston, S. C.

Medicare Publicity Labeled 'Absurd'

Recent publicity depicting the doctor as opposed to medical care for the aged is "absurd," a local physician told Exchange Club members.

Dr. Henry C. Heins, speaking on "Medicare," as the King-Anderson Bill has been abbreviated, pointed up what he considered disadvantages of the bill and gave some personal views on the possible outcome of the proposed legislation.

"Medical care for the aging is a definite problem," Dr. Heins said, but he cast some doubt on the sincerity of present administration's growing concern for it.

Getting down to the physicians' opposition to the King-Anderson Bill. Dr. Heins said. What disturbs doctors most is that the King-Anderson Bill is a "foot in the door" toward socialized medicine.

"I had an opportunity to visit seven countries in Europe last year and all had some form of government-controlled medicine. I was impressed with the apathy of the European physician who agreed that the situation was unsatisfactory, but was helpless to do anything about it. And there's no swing back to the other way," he said.

"Before you think you're getting something for nothing, you ought to remember the gigantic expense and that only those 65 and over and eligible for social security get it and that it would cover only 25 per cent of the cost of hospitalization.

"There is no such thing as federal funds. Congress has no Aladdin's Lamp or a financial wishing well. Every dollar that Congress spends comes from our earnings."

The Greenville-Piedmont

Local Doctors Prescribe Abstinence From Kennedy's Medicare Plan

By PAT PRIOR

Anyone in Greenville interested in seeing his physician grow uninhibited has merely to mention the King-Anderson bill. Doctors, who are usually reticent on political matters, will all but drag out a soap box and expound until you ask them to stop.

Doctors favor the Kerr-Mills bill, in effect since 1960 which provides aid to patients over 65 who are unable to pay, and is administered by the separate states. The federal government pays from 50 to 80 per cent of the cost.

Said one local doctor. "Under the King-Anderson bill, you have to get sick and get well on schedule — sick 90 days, then well 90 days, then sick 90 days."

"It's more than socialistic," claimed one. "It is dictatorial. It's the over-all picture of bureaucracy that doctors object to. It sets up commissars of health."

"It's an inroad," said another.

"I'm interested in two things—" said one doctor. "That the old people be treated with dignity and that there be no more encroachment on our freedom. The King-Anderson bill violates both of these."

"It will wind up costing more than the government originally estimated, just as socialized medicine has in other countries," one Greenville physician predicted.

"People are going to be gravely disappointed," warned another doctor.

In the meantime, the country's oldsters continue to rock quietly back and forth and hope that someone will do something about the high cost of medical care.

And the country's youngsters continue to wince each week when they look at their pay checks.

(*The State*), *Columbia, S. C.*, date line—Orangeburg

Owens Critical of Medicare

Congressional candidate Frank C. Owens said here Tuesday that the Kennedy-backed medicare bill "places politics at the bedside of the patient."

Dr. Owens, a Columbia physician, spoke at a meeting of the Orangeburg Rotary. He said he is not opposed to medical care for the aged, but is against the medicare King-Anderson bill.

Dr. Owens said the measure "does nothing for millions not covered by Social Security" and "it is the first step in socialized medicine."

Features in the bill, he said, would lower the quality of medical care, promote a shortage of prospective doctors who would fear socialized medicine and would eliminate the privacy of doctor-patient relationships.

Under the bill, Owens said, if a hospital chooses not to accept patients, the patients could not go there.

"This might mean the patient must go to another city to find a participating hospital. He therefore loses his choice of hospital and of physician.

"We think it is the wrong approach to medical care for the aged. We believe it will lower the standard of medical care and be an opening wedge for socialized medicine," he said. . . .

Greenville News :

The following comprises excerpts from a letter to the Editor printed under the title, "The President's Crash Programs".

> It is my purpose in this letter to review briefly those articles which bear on the crash program of the Kennedy administration to secure enactment of the King-Anderson Bill, which if enacted, would broaden the Social Security program to include hospital care of limited extent for beneficiaries who have attained their sixty-fifth birthdays.
>
> The leading editorial, "Leave Medical Profession Free," was a fair and wise statement and discussion of the faults of the Bill. You state quite correctly that "President Kennedy made it plain in his televised address to a party rally, that he is determined to force (italics mine) congress to pass his medicare bill . . . or else, Mr. Kennedy has demonstrated what he can do to politicians and big business men when they buck him . . . The methods by which the President seems to hope to get it across have dangerous connocations."

More from Greenville—

> Mr. Kennedy's method of forcing his will upon Congress is in contrast to that of Mr. Roosevelt who in his "fireside chats" was persuasive rather than demanding.
>
> Even though the vast majority of doctors who treat patients on a fee for service basis in contradistinction to those who draw salaries for teaching, research work, and institutional medical care, are thoroughly and unselfishly opposed to the proposed "medicare" program, they will without active antagonism, submit to the independent action of a Congress responsible to the will of the people, and not subservient to the will of the President. They quite agree with you when you wrote that "Legislation achieved by strong arm methods on the part of the executive, seldom is right."
>
> J. DECHERD GUESS, M. D.
> Greenville.

GOOD READING FOR THE SPEAKER

Opponents of the King-Anderson Bill will find an arsenal of ammunition in **Financing Medical Care, An Appraisal of Foreign Programs.** Caxton Printers, Ltd. Caldwell, Idaho. $5.50.

Edited by Helmut Schoeck, associate professor of sociology at Emory University, the book is a compilation of reports from 7 countries.

The views of 15 experts, economists, actuaries, political analysts, physicians, medical researchers, statesmen and a theologian, are backed up by fact and figure, leaving small room for argument in favor of government-controlled health care programs.

Editor Schoeck describes the book as "the first to provide an inside look at various systems of compulsory health insurance." A native of Austria, he was educated at the universities of Munich and Tubingen in West Germany, and is a systematic student and critic of government intervention in any sphere of life.

In his introduction Dr. Shoeck points out that half a century of health care in some of the countries which were studied has driven many people to look for any remaining alternative. From this point the book moves into a careful study of the effectiveness of medical systems in Great Britain, France, Germany, Austria, Sweden, Switzerland and Australia.

The evidence that government-control over medicine brings a general lowering of medical standards, poor medical care, too few hospitals, delays and waste is presented repeatedly.

Alfred Zanker, writing on Sweden—the only country where health insurance is completely integrated with social security, takes a dim view of the Swedish experiment. Mr. Zanker, a Swiss newspaperman stationed in Stockholm and an authority on economic and social affairs, points to a scarcity of physicians and nurses, and to a serious overloading of all medical facilities.

Turning to the economic factor, he shows that the steeply progressive income tax which is necessary to support Sweden's welfare state, has the middle-income family in a vice. There is little or no incentive left to improve their station. As an example he cites the family with annual earnings of $5,000 who must surrender 42% in taxes on any additional income.

Switzerland is unique in that compulsory health insurance is left to the individual canton or state. Dr. Marcel Grossman, professor of insurance economics at the School of Economics and Business Administration in St. Gallen, Switzerland, states that no Swiss politician would dream of running for office on a platform of inclusive compulsory health care. "The Swiss people," he said, "have voted it down again and again."

Today five cantons have no compulsory health insurance. Five cantons have uniform health insurance laws for their respective territories. Two of these cantons require health insurance for school pupils, one has limited obligatory health insurance for children and adults, and the other two require a limited compulsory system for adults only. Not a single canton has introduced compulsory health insurance for its entire population.

In conclusion Dr. Grossman states that there appears no likelihood of increasing the role of federal or local government in the area of health insurance. He adds that the Swiss citizen considers the British National Health Service, and other similar services, as failures, and is reluctant to delegate additional powers to the federal government.

From Great Britain, France, Germany and Austria the reports were pessimistic. The French system became so unwieldy that it actually caused a "doctors strike" against social security administrators in 1960. Australia has fared better. When the Labor government after World War II tried to introduce socialized medicine, the proposals were defeated.

The Liberal government which followed did not view the doctor as a scapegoat. In fact a physician, Sir Earle Page, was appointed Minister of Health.

Now in its 13th year, the Liberal party under Prime Minister Menzies, has carried out some welfare measures but with modifications in the interest of practicality.

(The author points out that the term "liberal" in Australia is "liberal" in the original sense, unlike the meaning in the United States, where "liberal" is defined as having socialistic tendencies.)

Today Australia has a National Medical Plan which is the result of cooperative work from state governments, doctors and druggists. Voluntary health insurance programs form the basis of the plan. The companies wishing to participate may do so by meeting certain basic requirements. There is no compulsion on the insurance company —or on the individual citizen. Many people still prefer independent plans and no special or separate tax is imposed on any Australian, nor is any charge withheld from his wages without consent.

In evaluating the plan Sir Earle Page says: "Australia has been fortunate. We narrowly escaped the trap of socialization set to enmesh medicine and other aspects of daily life. We have made up our minds in favor of a contributory health benefits scheme on a voluntary basis which is working smoothly and efficiently. In principle and practice the plan is well established and widely approved by the Australian people."

Turning for a look at the present attack on American medicine the former Health Minister points to five decades of high medical care standards in the United States and questions that these standards would be maintained under a government-controlled system.

News

Dr. Lawandales

Eleas F. Lawandales, M. D. announces the opening of his office at Palmetto Medical Arts Building, 112 Boland Circle, Charleston Heights, S. C.

Practice limited to Pediatrics.

AAPS Essay Contest

County and state medical societies and auxiliaries are invited to sponsor the 1963 AAPS Essay Contest for High School Students. This contest, the 17th annual national essay contest sponsored by the Association of American Physicians and Surgeons, offers contestants a choice of two topics: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System over Communism," and 14 prizes ranging from $1,000 to $75. Although actual writing competition does not need to start until approximately January 1, 1963, it is suggested that state and county societies which plan to sponsor the contest should appoint committees now so that plans can be completed, promotion started and requests made of schools early in September to include the Essay Contest in their regular school program. Inquiries regarding the AAPS Contest should be addressed to Dr. Thomas Parker, Suite 318, 185 North Wabash Avenue, Chicago 1, Ill.

Dr. Linker Opens Office

Robert P. Linker, M. D. announces the opening of his offices for the practice of Anesthesiology at 55 Doughty Street, Charleston, South Carolina.

Surgeon Joins Chamber Board

Dr. Ragsdale Hewitt, Sumter surgeon, has been elected by the Chamber of Commerce to its Board of Directors, filling the vacancy left by the death of W. T. Fort. Dr. Hewitt's term will expire in October, 1964.

Dr. Howard Snyder Accepts Medical College Residency

Dr. Howard Snyder, native of Greenwood, has accepted a residency in the department of radiology of the Medical College Teaching Hospital in Charleston.

He will be there for three years and then plans to practice in the field of radiology in the Charleston area.

Dr. Baker Presides At Meeting

Dr. Richard Baker of Sumter presided at the annual convention of the South Carolina Surgical Society, held June 7-10 at Sea Island, Ga. The 70-odd members of the Surgical Society convened with the South Carolina members of the American College of Surgeons.

Dr. Anderson Named President Of Lions Club

Dr. R. Maxwell Anderson has been installed as president of the Charleston Lions Club.

Sumter CD Hospital Approved

Sumter's 200-bed Civil Defense hospital has recently been inspected and approved by General Services Administration, federal agency which supervises Civil Defense facilities throughout the nation.

A crew from Rockwood, Tenn., checked the hospital's store, etc., and took a general inventory. Everything was found in order, and the inspectors were complimentary of the facility, stating that they intended to photograph it and distribute pictures and information to other Civil Defense units.

Plans to double the hospital's 200-bed capacity, to be financed through General Services Administration, were also announced.

Clarendon County Begins Program Of Mental Health

Thirty persons representing all sections of Clarendon County met recently to discuss the plans for the organization of a mental health program in the county.

The group voted unanimously to join with Sumter and Lee Counties in the promotion of a health center and an association for Clarendon.

Dr. J. A. Harmon To Practice At Pelzer Hospital

Dr. James A. Harmon, a native of Augusta, Ga., began the practice of medicine July 9 at the Pelzer Hospital.

Dr. Harmon replaces Drs. West and Tickle who practiced medicine at the Pelzer Hospital for the past several years. Both Drs. West and Tickle have left to take specialized training.

Dr. Harmon graduated from the Medical College of Georgia in 1961 and for the past year has served as an intern at Spartanburg General Hospital.

Dr. Von A. Long Gets Scholarship

Dr. Von A. Long, health officer for Union, Newberry and Laurens Counties attended the Trudeau School of Tuberculosis and Other Pulmonary Diseases held at Saranac Lake, New York, June 4-22.

Dr. Long is the recipient of scholarship funds provided jointly by the Union County Tuberculosis Association, Newberry County Tuberculosis Association and the Tuberculosis and Health Association of Greenwood-Laurens Counties.

Proposed Negro Nursing Home Gets More Funds

Over $5,900 in cash and pledges has been turned over to the fund raising committee of the proposed South Carolina Nursing home for the Aging and Handicapped by the Orangeburg County Teachers Association (Negro), according to Mrs. J. M. Penn, executive secretary.

Mrs. Penn said that the report was only a partial one made by the Rev. L. M. Tyler, OCTA president, and T. O. Sherman, chairman of the schools.

The city schools have given over $1,900 in cash and pledges.

Dr. Cutchin Heads State Organization

Dr. J. H. Cutchin of Easley has been elected president of the South Carolina chapter of the Sons of the American Revolution, winning the honor at the annual meeting of the group recently in Columbia.

Peeples Addresses Dietitians Group

Public health work labors under many a misconception, Andrew Peeples, chief of information service of the South Carolina Board of Health, told a group of dietitians at the second summer institute for dietitians and home economists sponsored by the Clemson-Winthrop Home Economics Research Council June 11-15. Mr. Peeples said "The public is inclined to believe that public health work is only with and for the very poor. This is not true—it affects us all." In his talk Peeples paid high tribute to South Carolina's physicians who have given of their services free of charge in support of public health. Dr. Edwin Boyle, Medical College of South Carolina, also took part in the program.

New Facility For State Hospital

Ground was broken June 10 for the $3,753,000 new building at the S. C. State Hospital in Columbia. The new facility, described as "the most advanced psychiatric treatment facility" in the country will serve two basic purposes. It will (1) be the center for receiving incoming patients of this institution for the mentally ill, and (2) the center for intensive treatment.

The need for such a building is shown by the fact that last year 3,057 persons were admitted to the Columbia division of the hospital, as compared with only 1,531 as recently as 1940.

The new building will relieve patient overcrowding to the extent of 212 beds. Completion is scheduled for January, 1964.

Dr. Elam Barred from S. C. Practicing

The former Calhoun Falls doctor, Lincoln P. Elam, who pleaded guilty to the charge of having falsely imprisoned a woman in a Calhoun Falls house, has been barred from practicing medicine in this state by the Court of General Sessions in Abbeville.

Speech and Hearing Clinic

A summer session of the 8th annual Speech and Hearing Clinic of Spartanburg is being held July 9-August 21 at the Spartanburg Speech and Hearing Clinic. The program is directed by Dr. Arthur Weiss.

Nursing Home Dedicated

The Faith Nursing Home of Florence was dedicated to community service Sunday afternoon, June 3. The new home is an extension of a facility founded in 1949 and operated continually since by two Negro practical nurses, Mrs. Vashti Williams and Mrs. Mae Wilson. The climax of the ceremonies was the presentation of the nursing home to the community by Mrs. Williams and its acceptance by Mayor David M. McLeod.

Dr. Thomas Honored

The Loris Community Hospital presented by Dr. J. D. Thomas, Sr. with a silver tray in honor of his 50th anniversary of his graduation from the Medical College of South Carolina. Dr. Thomas was the hospital's first chief of staff and is still an active member of the staff.

Aiken County Medical Society Criticizes Medicare

The Aiken County Medical Society has passed a unanimous resolution criticizing the controversial King-Anderson Bill which would provide medical care for the aged. The Society at the same time gave its support to the Kerr-Mills Act for medical care.

S. C. Public Health Association

More than 500 members and guests attended the 39th annual meeting of the South Carolina Public Health Association held at Myrtle Beach, June 7-10. The 3-day meeting was highlighted by four nationally prominent speakers who addressed the three general sessions.

Dr. Ward Honored

Dr. William Brien Ward, York County's senior surgeon, was honored for his 50 years of practice in medicine at a dinner in Rock Hill June 3. Some 200 people gathered to see Doctor "Jack" given a 50 Year Pin by Dr. James H. Gressette, president of the South Carolina Medical Association, and to hear Dr. Alton G. Brown, Dr. Ward's partner, tell the story of Dr. Ward's busy life. Dr. Ward was also honored by the York County Hospital Auxiliary who named their nursing scholarship the Dr. W. B. Ward scholarship.

Dr. Teague Attends Meeting

Dr. Martin M. Teague who was recently elected president of the South Carolina Thoracic Society, the medical section of the state Tuberculosis Association, attended the annual meeting of the National Tuberculosis Association held May 20-24 in Miami, Fla.

The Use of Poliomyelitis Vaccines in 1962

The Executive Committee of the State Board of Health on May 8, 1962, reviewed these recommendations and approved them as guides for South Carolina in 1962, summarized as follows:

1. *Mass Immunization*. In consideration of the large number of doses of inactivated (Salk) vaccine that has been given in the State and the nearness of the polio season, no mass immunization programs need be conducted during this summer except as epidemic control stated in No. 5.
2. *Infants*. Physicians and health departments should endeavor to complete the recommended immunization schedule for all infants by the time they reach their first birthday with either of the two vaccines. Schedules for both vaccines are shown in the included "Recommendations."
3. *Preschool Children*. These children should complete the recommended schedule of inactivated (Salk) vaccine already begun or initiation of a full course of oral vaccine may be chosen. The Salk vaccine is preferable during the summer polio season months because it immunizes against all types of polio beginning with the first dose where it requires three months to accomplish this result with the oral vaccine.
4. *All Others*. Inactivated vaccine is preferable during the polio season.
5. *Epidemic Use*. In any area in which three cases occur in a month by onset of illness two of which are the same type, consideration should be given to mass use of specific type oral vaccine. THIS WILL REQUIRE PROMPT REPORTING OF CASES AND PROPER SUBMISSION OF LABORATORY SPECIMENS FOR TYPE DETERMINATION.

G. S. T. Peeples, M. D.
State Health Officer

School Health

The nation's school children are receiving far from uniform protection against tuberculosis, despite the availability of "effective eradication procedures," a survey by the American School Health Association has disclosed.

Only nine states provide their school children with tuberculosis screening programs which fully meet the Association's standards, the chairman of its Tuberculosis Committee, Dr. J. Arthur Myers, reported at the annual meeting of the National Education Association. South Carolina is not among them.

Nearly 250 children under 14 years of age were killed by tuberculosis and several thousand additionally were disabled by the disease in the United States last year, Dr. Myers said.

"These tragedies resulted not from medical ignorance but from community complacency," he declared. "The tuberculin test offers all schools a practical means to screen their students for tuberculosis. The test identifies all persons who are harboring the germs of tuberculosis."

Dr. Louis Stephens To Practice

Dr. Louis M. Stephens will begin the practice of medicine in Clinton in July, it was stated this week. He will be associated with Dr. George R. Blalock and Dr. R. M. Fuller.

He is completing a year of general practice residency at the Huey P. Long Charity Hospital at Pineville, La., which is under the auspices of Tulane University.

Dr. Stephens, a native of Canton, N. C., is a graduate of the Medical College of South Carolina and served his internship at the Macon Hospital, Macon, Ga. He received a Mead-Johnson scholarship for a year of general practice residency at the Louisiana institution.

Dr. Stephens is a graduate of Clemson College with a BS degree in education.

After graduation, he served in the army for three years as an infantry officer, with 18 months in Korea.

Upon separation from service, he returned to Clemson for a year's study and received his master's degree in education. He then entered upon his medical studies.

Memorial Plaques Placed In Marion Hospital

Two new name plaques have been installed recently on doors at the Marion County Memorial Hospital.

One was given in loving memory of Dr. Zack Godfrey Smith, beloved physician of Marion from 1919-1935. This plaque was donated by his daughters, Mrs. Elise Smith McCandlish and the late Mrs. Tot Smith Johnson.

Dr. Ackerman And Family Are Honored

Dr. and Mrs. R. E. Ackerman and children were honored by the people of Bethune at a drop-in at the Regional Rescue Squad House. The family has won the hearts of the people, which he served as the doctor of this area, and it is with regret he leaves, but with delight that he can continue his studies, and will be in Charleston.

Camden Chronicle

Dr. Gilliland Elected

Dr. O. E. Gilliland, Jr. defeated Clyde Crocker for the District 4 seat on Spartanburg County Board of Education.

Bowers Is New Jaycee Leader

Dr. James Bowers was installed as new president of the Walhalla Jaycees at annual installation services held this year at the Oconee State Park dining hall. He succeeds John D. Long in that capacity and will serve for the 1962-63 session.

Officers of S. C. Surgical Society

Dr. Alton G. Brown of Rock Hill is the new president of the South Carolina Surgical Society following his election at a joint meeting of the society and the American College of Surgeons in Sea Island, Ga.

Dr. Manly Stallworth of Charleston is vice-president and Dr. John R. Timmons of Columbia is secretary-treasurer.

Dr. Stallworth's mother lives in Chester.

Dr. Brown, son of Mrs. J. J. Brown and the late Rev. J. J. Brown of Rock Hill, is a member of the York County Medical Society, South Carolina Medical Association, American Board of Surgery, International Board of Surgery and Southern Surgical Association.

He is a fellow of the American College of Surgeons and is past president of the South Carolina chapter.

Deaths

DR. C. I. GREEN

Dr. Carlos Izlar Green, 89, retired physician of 145 Lovell S. E. died June 5 at Orangeburg Regional Hospital after illness of a few days.

Dr. Green was born near Orangeburg. He was a member and honorary steward of St. Paul's Methodist Church, a veteran of World War I, a graduate of The Citadel and Medical College of South Carolina. He served as president of the Orangeburg County Medical Society and also chief of staff at Orangeburg hospital. He also taught in the School of Nursing.

DR. REUBEN G. HAMILTON

Dr. Reuben Gilliam Hamilton, 86, retired physician of near Chapin, died at the Lakeside Rest Home June 6 following a long illness.

Dr. Hamilton was born near Herbert, Union County, on February 7, 1876.

He was graduated from the University of Georgia Medical College in the class of 1902. Since that time he had practiced medicine in Spartanburg, Union and Fairfield counties prior to World War I.

In June of 1917 he with Dr. Marion H. Wyman organized the S. C. Volunteer Ambulance Company, in which he first served at Allentown, Pa., as first lieutenant, M. C. He was transferred to Tobyhanna, Pa., where he served as adjutant of the Ambulance Training Center until he was sent overseas in December of 1917. He served with Hq. US Army Ambulance Service with the French Army as adjutant under the late Gen. Percy Jones until April of 1918. He was transferred by request to the 26th Division and served as deputy commanding officer, 101st Sanitary Train until December 5, 1918, and was honorably discharged on October 28, 1919, as a major, M. C.

Doctor Hamilton was awarded the Distinguished Service Cross, Division Citation and French Croix de Guerre for extraordinary heroism in action near Marcheville, France, September 25-26, 1918. "He established and maintained an ambulance dressing station in an advanced and hazardous position, where he labored unceasingly, treating and evacuating the wounded throughout the day, in full view of the enemy and under heavy bombardment. Knowing that our troops were withdrawing and the enemy about to enter the town, he continued his aid to the wounded, even after permission to withdraw had been given him by his commanding officers."

Doctor Hamilton served as Fairfield County health officer from March, 1920, until 1923 and as malariologist with the S. C. State Board of Health until 1929, when he went with the S. C. Electric & Gas Company in the same capacity and served until his retirement in 1951.

He was a member of the S. C. Medical Association and the American Medical Association.

Excerpts From a Resolution of The Columbia Medical Society
DR. WILLIAM WESTON, SR.

The Columbia Medical Society, the Medical Profession in South Carolina, the citizens of Columbia and of his native state and nation, sustained a great loss Sunday morning, June 17, 1962, in the death of Dr. William Weston, Sr., aged 87.

Many terms of veneration and esteem may be applied to this beloved physician; Dean of Columbia physicians, Nestor of the medical profession in Richland County, Grand Old Man of pediatrics in South Carolina, Patriarch of a distinguished clan of doctors and citizens.

During his professional life, Dr. Weston began the practice of medicine in 1897. He gave of himself unceasingly to those in every walk of life. His great love of people was shown throughout his lifetime. He, in turn, was loved and admired by all who knew him. His gentleness and concern were felt by both children and parents alike.

Dr. Weston was an unusual person in his many interests and skills. His humor and charm endeared him to all. He loved the out-of-doors, yet was an inveterate reader and prolific writer.

Dr. Weston was a pioneer in infant feeding and nutrition. He was recognized in this field throughout the United States. His studies on acrodynia are internationally known, in addition to which he contributed to the solution of both hookworm and pellagra problems. His scientific, inquiring mind included also the value of iodine in preventive medicine, resulting in South Carolina's being acclaimed "the Iodine State".

His leadership in medical affairs was not limited to his county and state, but extended to the councils

of the American Medical Association where his wise guidance was recognized. He helped steer the A.M.A.'s policies for over fifteen years, during which time great progress was made.

Truly this physician was one of South Carolina's greatest. His loss will be felt greatly as attested by the many editorials acclaiming him as a teacher, researcher, practitioner and true physician.

The affection and veneration felt for him by the people of Columbia and throughout the state of South Carolina was notably demonstrated by the large concourse of doctors, friends and former patients who attended his last rites at Trinity Church and his interment in the lovely and restful cemetery adjacent to St. John's, Congaree.

RESOLVED, therefore, that the Columbia Medical Society has lost its most venerable and distinguished member, a physician living up to all the Hippocratic ideals as well as to the best traditions of his state, his section, and his community; one who will be remembered as long as the youngest member of this Society is alive.

RESOLVED FURTHER, that a copy of these resolutions be spread on the minutes of this Society, that they be published in THE RECORDER, and that a copy be presented to the bereaved family along with the love and sympathy of this Society.

/s/ O. B. Mayer, M. D.
C. J. Milling, M. D.
T. A. Pitts, M. D.

Resolution by The Columbia Medical Society
THEODORE JERVEY HOPKINS, M. D.

Theodore Jervey Hopkins, M. D., affectionately known to members of this Society and to his multitude of friends as "Hop", died early Sunday morning, May 13, 1962, after an illness of a little more than one year. He was the senior member of the orthopedic group of Hopkins, Weston and Cook. Knowing from the very first that he faced the deadliest of enemies, he remained cheerful throughout the weary months of waiting, going to his office much of the time except when necessity forced his hospitalization.

Born at Old Field Plantation January 23, 1901, Dr. Hopkins was the son of the late English Hopkins and his wife, Laura Jervey Smith. He was educated in the local public schools, Colonel Banks' Coaching School, Clemson College, the University of South Carolina and the Medical College of South Carolina, receiving his M. D. degree from the latter institution in 1925.

He served his internship at the Columbia Hospital, and a surgical residency and a chief residency at Philadelphia Orthopedic Hospital, Philadelphia. His entire professional career was spent in Columbia.

Dr. Hopkins was a member of one of Richland County's and South Carolina's oldest and most distinguished families. Long an authority on the history of lower Richland County, he had made extensive notes on the subject. A man of unusual memory, he possessed a remarkable faculty for recounting the many fascinating incidents in his collection, and was possessed of a rich fund of anecdotes. His was a genial personality and to be an acquaintance was to become a friend.

On November 20, 1932, he married Miss Jane Calvert McDowell of Columbia.

Dr. Hopkins was a member of the following professional societies: The Columbia Medical Society, American Medical Association, Industrial Medical Association, Southern Medical Association, South Carolina Orthopedic Association, American Railway Surgeons, Southern Railway Surgeons, Atlantic Coast Line Railway Surgeons and Seaboard Airline Railway Surgeons. He was a member of Trinity Episcopal Church.

Among his social memberships were the Forest Lake Country Club, the Palmetto Club, the Columbia Cotillion, the Centurion Society, Kappa Sigma Fraternity, Richland Lodge 39 AFM and the South Caroliniana Society.

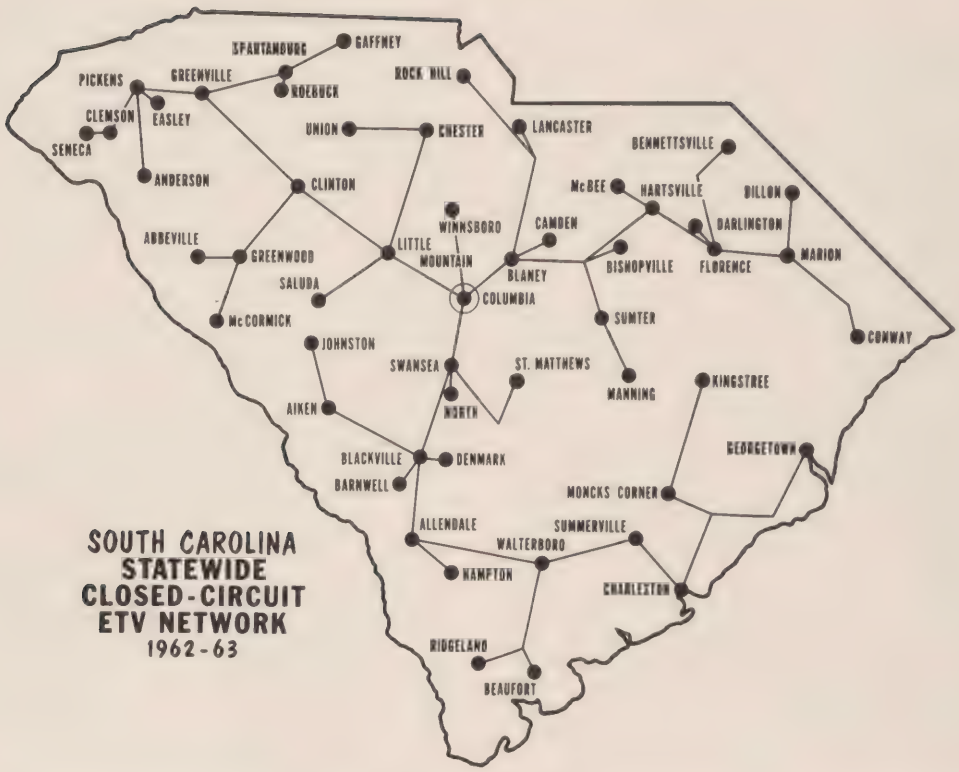
It is difficult for the members of this committee to pay tribute to "Hop" without becoming unduly sentimental or emotional. One has been a friend since childhood; another has known him affectionately since medical collegee days and the third is a professional partner in his specialty. But for all members of the Columbia Medical Society, we are sure the verdict would be the same: a truly lovable friend has gone; a many-sided gentleman, talented, loyal, professionally eminent, socially charming and blessed with a great sense of humor and a tolerance for the foibles and weaknesses of his fellow man.

Theodore Hopkins represented a type all too infrequently seen in today's mad scramble for success. Proud of his fine heritage, he nevertheless exhibited the unobtrusiveness and courtesy of an era that is very nearly gone. At home in the highest circles, both social and professional, he could instantly put at ease the youngest colleague or the humblest laborer. The affection in which "Hop" was held was amply demonstrated by the hundreds, from all walks of life, who either called at the home or attended his funeral. He was laid to rest in the Hopkins family cemetery at Back Swamp in the county he loved best of all the regions of the earth. In recent years he often referred to this lovely spot and he had recently surrounded the ancient sandstone wall with a handsome wrought iron fence. Truly a great gentleman has joined the generations of those from whence he came.

RESOLVED, therefore, that in the death of Theodore Jervey Hopkins, the Columbia Medical Society has lost an outstanding member who was an ornament to the profession of medicine and whose memory furnishes a splendid example to those of us who are permitted to labor on earth a while longer.

RESOLVED, further, that a copy of these resolutions be spread on the minutes of this Society; that they be published in THE RECORDER, and that a copy be sent to the family with the sympathy and affection of this Society.

/s/ William Weston, Jr., M. D., Chapman J. Milling, M. D., Weston C. Cook, M. D.



MEDICAL TELEVISION IN SOUTH CAROLINA

DALE GROOM, M. D.
Department of Medicine
Medical College of South Carolina

Of special interest to practicing physicians of South Carolina is the tremendous expansion taking place this summer in the Educational Television Network linking schools all over the State with the central studios in Columbia. When schools reopen in September this network will be more than twice as extensive as last year, fanning out into every county of the State and including more than 130 schools and at least 2 hospitals.* A notable first for South Carolina in the field of education, this pioneer achievement is supported by funds from our State with an appropriation for 1962-63 of more than one and a quarter million dollars. Daily during school hours its coaxial cable and microwave relay hookup carries television lessons in geography, history, algebra, science, etc. by outstanding teachers supported by almost unlimited visual aids and a professional production staff of high caliber. The ETV programs are transmitted through a closed circuit system rather than open broadcast, hence cannot be viewed on home receivers.

Medical use of the network began in November 1961. A series of 1½ hour programs on subjects of general interest have been produced on a once-a-month schedule by the Division of Postgraduate Education of the Medical College of South Carolina in collaboration with the ETV staff. The format has been that of panel discussions by members of the faculty and guest speakers, followed by question and answer periods. Tape recordings of the programs have been sent over the network the following night for physicians unable to attend the live performance. To date the following symposia have been produced:

1. Differential Diagnosis of Chest Pain.
2. Headache.
3. The Lump in the Breast.
4. Peptic Ulcer.
5. Treatment of Hypertension.
6. Pitfalls in the Treatment of Fractures.
7. Part I — Space Medicine.
   Part II — Medical Disaster Planning.

All of these programs have been preserved on tape and some of them may be re-run this next year if there is sufficient demand.

Plans for the 1962-63 series call for resumption of programs in September with a similar format and a similar monthly schedule. A grant of $12,350 from

*First hospital to connect into the network was Columbia Hospital, enabling their staff to view the programs there. Cost of such a connection depends upon distance between the hospital and the closest existing network outlet—in many cases the line charges may be quite nominal. An additional benefit of an outlet in the hospital is an extension in the pediatric department where the children may attend the TV school lessons during the day.
Inquiry to the local telephone office will determine cost of an ETV installation. Or the inquiry may be addressed to the Educational Television Center, 2712 Millwood Ave., Columbia, S. C.

the Merck, Sharp & Dohme Postgraduate Program was received recently and will be used to cover expenses of guest speakers, travel, cost of TV tape, line charges for an outlet in the Medical College Hospital and promotion expenses. It should be noted that no charge is made for use of the network itself nor for the collaboration of the Elucational Television Staff in Columbia; our utilization during evening hours of these facilities is actually an extra dividend on the State's investment. (Other evening programs are planned and underway for the network, including adult education courses and a series of programs for nurses). Very likely demands on the network will increase in the future and, in a sense, the schoolhouse may be regaining some of its former prestige as a cultural center of the community.

Arrangements must be made with the local school authorities for opening the schools at designated evening hours. Necessarily that responsibility devolves upon the doctors themselves and in many cases county medical societies have taken the initiative. A few instances have been reported of nominal charges being requested by the schools to defray cost of extra janitorial services, etc. Occasionally there has been some difficulty arising from improper adjustment or tuning of the TV receivers in the classrooms. Technical problems, however, have been rare, and excellent reception has been the rule with picture quality excelling that obtained with open broadcast. Several methods of telephone communication with the Columbia studios for relaying questions to the panel have been tried with variable success; it is hoped that a more efficient system of handling the questions will be devised in order to retain the advantages of active participation in the programs by viewing physicians. Because of the excellent cooperation of the more than 30 members of the ETV staff, actual production of programs has posed no real problem—it has, in fact, been a remarkably satisfying though laborious experience for all participants. As with commercial television broadcasts it is exceedingly difficult to get any reliable estimate of the number of viewers and their reactions although we have received a good many encouraging letters from around the State. More precise information on this will be sought later by means of a questionnaire.

How effective is this method in Postgraduate Medical Teaching? That question cannot be answered with any validity at this stage of our experience. While the medium of television affords unprecedented versatility and coverage it is virtually a one-way method of communication except for the feedback afforded by the telephoned questions, the letters and comments. Such evidence as we have been able to garner indicates that attendance at the TV sessions equals or exceeds that of any medical program held in South Carolina and probably the attendance will more than double with the expanded network. Moreover there is reason to believe that many physicians who do not ordinarily attend scientific programs and postgraduate courses—perhaps largely because of the heavy demands of practice in a state with the lowest physician-to-population ratio in the South—view the TV programs without having to journey far from their communities. And certainly a stimulus is afforded by the eminent medical speakers who can be brought to our State to participate in scientific sessions of this coverage. But as to how much one's methods of practice may be influenced by television teaching, that is another matter. If we may judge by estimates of its effectiveness in the schools where measurements are made by standardized testing methods, or by the popularity of medical TV demonstrations at some of the large medical meetings, this investment of time, effort and funds is well worthwhile.

I am convinced that postgraduate or "continuation" education of practicing physicians affords the best means of elevating quickly the standards of medical practice in any area. If subject matter can be kept at a practical level, spiced with a little stimulus of current research and presented in a lucid and organized manner, informally and without tiresome speeches or reading of manuscripts with hackneyed phrases, these medical TV sessions can compete effectively for the attention of the already overburdened practitioner and can contribute directly to better medical care.

CLOSED CIRCUIT SCHOOLS

ABBEVILLE COUNTY
Abbeville
Abbeville High School
Wright High School
AIKEN COUNTY
Graniteville
Leavelle McCampbell High School
ALLENDALE COUNTY
Allendale
Allendale Training School
Fairfax
Allendale Fairfax High School
ANDERSON COUNTY
Anderson
McCants High School
Westside High School
BAMBERG COUNTY
Denmark
Denmark Olar High School
Voorhees High School
BARNWELL COUNTY
Barnwell
Barnwell High School
Barnwell Junior High School
Butler High School
Blackville
Blackville High School
Macedonia High School
Williston
Williston Elko High School
Kelly Edwards High School
BEAUFORT COUNTY
Beaufort
Beaufort Junior High School
Robert Smalls
BERKELEY COUNTY
Moncks Corner
Berkeley High School
Berkeley Training School
CALHOUN COUNTY
Cameron
Cameron High School
St. John High School

St. Matthews
John Ford High School
St. Matthews High School
CHARLESTON COUNTY
Charleston
Rivers High School
Simonton High School
Charleston Heights
Chicora High School
CHEROKEE COUNTY
Gaffney
Gaffney Senior High School
Granard High School
CHESTER COUNTY
Chester
Chester High School
Finley High School
CHESTERFIELD COUNTY
McBee
McBee High School
Pine Forest High School
CLARENDON COUNTY
Manning
Manning High School
Manning Training School
COLLETON COUNTY
Walterboro
Colleton High School
Walterboro Senior High School
DARLINGTON COUNTY
Darlington
Brunson-Dargan High School
Mayo High School
Saint John's High School
Hartsville
Hartsville High School
Hartsville Junior High School
Butler High School
DILLON COUNTY
Dillon
Dillon High School
Gordon High School
DORCHESTER COUNTY
Summerville
Alston High School
Summerville High School
EDGEFIELD COUNTY
Edgefield
Edgefield High School
Johnston
Johnston Training School
Strom Thurman High School
FAIRFIELD
Winnsboro
Fairfield County Training School
Winnsboro High School
FLORENCE COUNTY
Florence
McClenaghan High School
Poynor Junior High School
Southside High School
Wilson Senior High School
GEORGETOWN COUNTY
Georgetown
Howard High School
Winyah High School
GREENVILLE COUNTY
Greenville
Parker High School
Washington High School
GREENWOOD COUNTY
Greenwood
Brewer High School
Greenwood Senior High School
HAMPTON COUNTY
Estill
Estill High School
Estill Training School
Hampton
Wade Hampton High School
Varnville
North District High School
HORRY COUNTY
Conway
Conway High School
Conway Junior High School
Whittemore High School
JASPER COUNTY
Ridgeland
Jasper High School
Ridgeland High School
KERSHAW COUNTY
Blaney
Blaney High School
Camden
Camden Junior High School
Camden Senior High School
Jackson High School
LANCASTER COUNTY
Lancaster
Lancaster Senior High School
Barr Street High School
LAURENS COUNTY
Clinton
Clinton High School
Clinton Junior High School
Bell Street School
LEE COUNTY
Bishopville
Bishopville High School
Dennis High School
LEXINGTON COUNTY
Cayce
Brooklan-Cayce High School
Swansea
Monroe Pinckney School
Swansea High School
McCORMICK COUNTY
McCormick
McCormick High School
Mims High School
MARION COUNTY
Marion
Johnakin High School
Marion High School
MARLBORO COUNTY
Bennettsville
Bennettsville High School
East High School
NEWBERRY COUNTY
Prosperity
Mid-Carolina High School
OCONEE COUNTY
Seneca
Blue Ridge High School
Seneca High School
ORANGEBURG COUNTY
North
Dover High School
North High School
PICKENS COUNTY
Central
Daniel High School
Clemson
Calhoun-Clemson Elementary School
Easley
Clear View High School
Easley High School
Pickens
Liberty High School
Pickens High School

RICHLAND COUNTY
Columbia
A. C. Flora High School
Booker T. Washington High School
C. A. Johnson High School
Columbia High School
Crayton Junior High School
Dentsville High School
Dreher High School
Hand Junior High School
SALUDA COUNTY
Saluda
Riverside High School
Hollywood High School
Saluda High School
SPARTANBURG COUNTY
Roebuck
Roebuck High School
Spartanburg
Carver High School
Cleveland Junior High School
Cumming Street Junior High School
Frank Evans Junior High School
Jenkins Junior High School
SUMTER COUNTY
Sumter
Alice Drive Junior High School
Edmunds High School
McLaurin High School
Lincoln High School
UNION COUNTY
Union
Sims High School
Union High School
WILLIAMSBURG COUNTY
Kingstree
Kingstree High School
Tomlinson High School
YORK COUNTY
Rock Hill
Emmett Scott High School
Rock Hill High School
Winthrop Training School

CORONARY HEART DISEASE

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W. B. SAUNDERS COMPANY

features the following recent books in their full page advertisement appearing elsewhere in this issue:

KLINE and LEHMANN—HANDBOOK OF PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE
Tells the non-specialist which psychiatric patients he should and should not treat—why he should treat them—and exactly how to manage these patients.

FINNESON—DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES
Step-by-Step management of commonly met problems of pain—ranging from headache to intractable pain due to cancer.

WILLIAMSON—OFFICE PROCEDURES
Step-by-step instructions with over 1,000 illustrations on how to perform office techniques—ranging from removal of excess cerumen to cautery of the cervix.

Doctors Unhappy With Legislation On Mental Health

A prediction that the field of mental health will become "an enormous federal empire" in the next 10 to 20 years has been made by a special committee of the Charleston County Medical Society.

The Committee on Mental Health Legislation, headed by Dr. Jennings Cleckley, has issued a preliminary report to the county society after reviewing and studying the mental health laws of the state.

It also reviewed the proposals set forth by the Joint Commission on Mental Illness and Health in "Action for Mental Health."

After completing a major part of their study, the committee, headed by Dr. Jennings Cleckley and including Dr. Vince Moseley, Dr. Rhett Talbert, Dr. Sidney Cromer and Dr. F. M. Ball, reported that:

"The Community Mental Health Service Act and Policy Statement has a defect that far outweighs its merit, namely that it tends to take care of the mentally ill out of the hands of the medical profession and concentrate the responsibility in the hands of so-called para-medical or even non-medical groups."

The doctors endorsed the implied policy, however, of concentrating mental health action on the local community level.

But they point out that "this program does not and cannot solve the problem without adequately trained psychiatrists in adequate numbers.

"If these programs were to be set up as presently outlined in this Act and Statement of Policy, many of the community programs would of necessity be operated by non-medical personnel.

"This opens wide the door for the development of a situation in which technically trained para-medical personnel without any supervision by or responsibility to qualified psychiatrists might soon be in control of this important field of medicine."

The report suggests that "South Carolina must develop a Community Mental Health plan, but it should be done only on a sound medical basis."

In a 20-page report, the committee pointed out that the Community Mental Health Services Act "does not provide for any medical personnel whatsoever as a requirement of a community mental health program."

The committee recommended that amendments be sought to the act to provide:

That no mental health program shall have available state funds or approval by the S. C. Mental Health Commission unless there is at least one doctor of medicine certified in psychiatry serving on the board.

That both the program director and the medical director of every community mental health program shall be qualified psychiatrists.

The group also said that a federal agency, probably the Department of Health, Education and Welfare, will centrally regulate all the mental health facilities in the nation, both at a state and community level within the next 10-20 years.

—The Joint Commission would place the program largely in the hands of non-medical people. "That it would become primarily a political empire seems inescapable," according to the report.

—That patients cared for by "this great central government enterprise" will, for the most part, be admitted to it involuntarily, maybe subject to out of state transfer, and will be released by this agency at its own discretion or held in another state for "post-institutional discharge" and observation, if treated at an out-of-state facility.

The Interstate Mental Health Compact, which became law in South Carolina in 1959 and has been passed by all state legislatures, came in for particular criticism.

The compact, in general, provides that a person needing hospitalization because of mental illness or mental deficiency will receive care and treatment regardless of his legal residence and may be transferred to a hospital in another state on the basis of clinical considerations. It also permits co-operative interstate arrangements for aftercare of convalescing patients and for the development of joint facilities.

The committee strongly criticizes the lack of a requirement of the permission of the family or guardian of the patient to be transferred. It believes such written permission should be mandatory.

The Charleston doctors note that a general revision of the basic mental health laws of the state has been carried out since 1952, and that additional legislation is anticipated.

In general it feels that South Carolina is following a pattern now becoming standard for all states.

"There has been in the last 10 years a concentrated effort to standardize mental health legislation in every state of the Union," according to the report, "so that the various provisions and even the wording are almost identical for each state's laws."

The committee said this similarity is pointed out to indicate there are evidences of central overall planning for mental health legislation for the entire nation from a not definitely identified source and that this planning extends down to the community level without apparent local consideration but by the adoption of model laws.

NIH

The Clinical Center of the National Institutes of Health has just published a new revision of "Current Clinical Studies and Patient Referral Procedures." The publication describes briefly the diagnostic requirements, purposes and methods of those studies expected to be most active during the current year.

Physicians desiring to receive a copy of the publication should write to Dr. Jack Masur, Director of the Clinical Center, NIH, Bethesda 14, Maryland.

SOUTH CAROLINA MEDICAL ASSOCIATION
MINUTES OF THE
ONE HUNDRED FOURTEENTH ANNUAL SESSION
OF THE HOUSE OF DELEGATES

OCEAN FOREST HOTEL **MYRTLE BEACH, S. C.**

MAY 8, 9, 1962

DR. CHARLES N. WYATT, Presiding

THE CHAIR: I will call the 114th annual session of the House of Delegates of the South Carolina Medical Association to order. We will have the invocation by Dr. M. D. Moore, pastor of the Myrtle Beach Methodist Church. (Convention rises for the invocation.) (The Chair thanks Dr. Moore.)

Report of the Credentials Committee—
James L. Wells, Chrm.

DR. WELLS: The Credentials Committee have checked the credentials of the delegates at this time and report there are 55 official delegates checked in. I believe this is a quorum.

THE CHAIR: Thank you very much; it is a quorum. I want to say, gentlemen, in opening this session that this afternoon, as you well know, most of the procedure will be the hearing of committee reports and most of these have been published in the *Journal* of April 1962. As we go down the line these committees will be asked if they have a supplemental report and if they do they will be allowed to render such, and then we will assign these reports to the various reference committees. There will not be any discussion of these reports this afternoon. They will be assigned to reference committees and if you have anything you want to say, and I hope you do, you will appear before the reference committees when they convene at about five o'clock this afternoon. And I would like you to get it off before these committees rather than let it store up until in the morning.

(Opening Remarks by the President)

It has been a pleasure to serve you as president this year. I have tried to represent you in the best way that I knew how. I haven't made ten thousand miles over the state at your meetings, as Joe Cain did, because he is a younger man than I. I didn't expect to follow him in that respect. However, I have tried to represent you as best I could wherever and whenever and in whatever capacity I was asked that had anything to do with the Medical Association in this State. I hope that I have created to some extent some interest and I hope that it has been good.

(Introduction of President-elect)

I would now like to call on Dr. James H. Gressette, President-elect and let you see him. Toolie, would you come forward please?

DR. JAMES H. GRESSETTE: Dr. Wyatt and fellow delegates to the South Carolina State Medical Association, I would like to say, Charlie—we appreciate all that you have done for us. I feel very small in trying to follow a very efficient, a very good and a very effective president of this State Association and I hope that as the year wears on that we will get along, not as well, but just almost as well. Which reminds me of a little story. You know it was said that there was a woman about 80 years of age who ran into a policeman down town on the corner and she said, "Sir, I would like to report that a man came up and kissed me on this corner." And the policeman said, "When did it happen?" And she said, "Forty years ago." And he said, "Why tell me now?" And she said, "Oh, I just love to talk about it, now." Now, it gets back to this—you represent the membership of the South Carolina Medical Association. I don't want to come back here next year and just hear you talking about it, because what we do next year is going to depend on what you are going to do. Thank you Charlie. (Applause)

THE CHAIR: There will be some changes in the membership of the various reference committees, as follows:

Legislation and Public Relations—I name Dr. Cantey chairman instead of Dr. Shealey.

Public & Industrial Health—I see Dr. Hall will not be here so I replace him with Dr. R. F. Lemmon, Jr., and Dr. Sam Fisher will not be here, so he will be replaced by Dr. E. W. Masters.

Amendments to Constitution & By-Laws: Dr. Carr T. Larisey is not here; I replace him with Dr. R. G. Mann.

Insurance, Blue Cross, Blue Shield—Dr. James E. Bell, Jr. is not here. I am replacing him with Dr. C. R. May. (Dr. May was not present) Dr. Joel W. Wyman named as replacement.

Sergeant-at-Arms and Tellers—Dr. Charles R. Propst is not present he will be replaced by Dr. J. G. Appleby.

If any of you know of any members of your committee not being here will you please let me know so that we may replace these members so that they may get to work immediately following the recess this afternoon.

I would like to remind you, too, gentlemen, that we are not going to re-register this year by a whole lot of argument. As you remember last year this house passed a resolution that this matter should be referred to the county societies and that the matter would be taken up by the individual societies and that you were supposed to be here ready for a vote when the thing was asked. Your county society secretary should have received a memorandum to this effect some six or eight weeks ago and I presume and I hope and I do understand that you will be ready to vote when the matter comes up tomorrow. We will not have any resolutions withdrawn and tabled as we have had for the past two or three years. I am not going to be hard-boiled but there is no need to be rehashing this thing again.

THE CHAIR: At this time I would like to call on Dr. Jim Plaxco who is here as a general delegate from the Pharmaceutical Association of South Carolina, Dr. Plaxco.

DR. J. PLAXCO: Dr. Wyatt, members of the House of Delegates of the S. C. Medical Association, Mr. Meadors: I bring you greetings from the Pharmaceutical Association of the State of South Carolina.

Please allow me to express my pleasure in being with you today. President Mabry asked that I express, for him, his sincere regrets that he could not be here, but he had a previous commitment. He is attending our State Officers night in our thirteenth district in Greenville.

Last year at our State Convention, one of your members, Dr. Gordon Howle, appeared on our program. During his talk he suggested that our Associa-

tion and yours invite annually a fraternal delegate. This was looked upon with favor in our House of Delegates and we invited one of your members, Dr. Julian Price, to appear on our program in June. He has accepted this invitation and I, in turn, was selected to appear before your august body.

Not too far from here there are two churches that are situated each on the corner just opposite the other. These two churches have many things in common, the architecture of the buildings are alike: the masonry, the material of which they are built is identical, they have the same type vestibule, the same number of steps, the seating arrangement is the same, they have a great many things which are just alike, but they do have a difference—the doctrine of the church on the left corner is "there ain't no hell", the doctrine of the church on the right corner is "to hell there ain't." Now, there are two ancient and honored professions, which have many things in common. The educational requirements are similar. The years spent in school are comparable. The same applies to each one's apprenticeship. Each has to undergo rigid state board examinations for licensure. Each has a standard of ethics very much alike. Yes, our two professions have much in common.

Pharmacy is one of the oldest, if not the very oldest profession we have any record of. The first mention is in the book of Exodus, when we read in Chapter 30, beginning at the 23rd verse:

Take of Myrrh ----------500 shekels
Sweet Cinnamon ----------250 shekels
Sweet Calamus ----------250 shekels
Olive Oil ---------- 1 hin

To be compounded after the art of the apothecary. Medicine is, perhaps, not so ancient.

The two professions are so very closely associated that one without the other is incomplete. Taken together they form a team well worthy of the trust and confidence placed in them.

These two professions were looked upon as one until the year 1240, when Frederick II, King of the two Sicilies, by Imperial Edict granted the pharmacist independence from medicine and established legal responsibilities for each.

The services of the pharmacist are correlated with those of the physician and the activities of this group are dedicated to the promotion of health and the fighting of disease. Fundamentally, the pharmacist is a medical specialist whose chief responsibility is the preparation, standardization and preservation of drugs and the compounding of prescriptions written by the physician.

The chief responsibility of the physician is to diagnose, after a thorough examination, and determine the proper treatment for the patient. He must conclude that certain medicines are needed and the best means of combining and administering them in order to obtain the maximum benefits with the minimum of discomfort to the patient. Yes, our two professions have many problems in common. We are co-responsible and in this together. To mention a few of the most common problems that loom foremost, we look with alarm on socialized medicine. Our present national administration looks with favor on this monster, as evidenced by current legislation to furnish medical care and medication to the indigent and aged. This is only the beginning, and once a foot is in the door soon the door will be wide open and we will have socialized medicine. Another catastrophe immediately in front of us is our National Civil Defense. I shudder as I realize a nuclear warfare could begin almost any moment by ruthless powers, and if and when this does happen, every available man and woman will be needed. While we, as pharmacists look to you as doctors to take the initiative and instruct us as to our part in this emergency in providing adequate well stocked depots, in strategic locations, with first aid supplies and all other necessary equipment, while we are not fully qualified to render all first aid treatment, we stand ready and willing, at your command, to render any and all services we are able to do. A third calamity, and don't forget that we are in this together, is the Kefauver investigation, which I think is unwarranted, distorted, one-sided, biased and altogether unfair. When he brayed about a 7000 per cent mark-up, he is engaging in the deliberate demagogery so typical of the man. To us his charges are so ridiculous that I feel no defense is necessary. What his investigation failed to show is:

1. Mortality rates of eight (8) major infectious diseases have been reduced 56%.
2. Average hospital stay reduced to 5.7 days.
3. Life span increased from 49 years in 1900 to 70 years today.

Much could be said about many other problems we have in common, but we must pass on.

We, also, have some differences. The statements we are about to make are made in the friendliest spirit and are intended only to provoke thought—not to start a controversy, if you please—and thus bring about a closer spirit of cooperation and understanding. We know you physicians do not approve nor appreciate counter prescribing by us pharmacists. Nor do we pharmacists approve of physicians dispensing or doling out manufacturers' samples to other than indigent patients.

Another mistaken idea some doctors may have is to tell a patient to go to a drug store and call for a prescription by name, informing the patient that the price will be cheaper than when a prescription is given. Oftentimes this proves embarrassing to the pharmacist, for many times the preparation carries the legend and cannot be sold over the counter.

Again, we think it unfair for a physician to tell the patient the price of a prescription. The opinion is that the physician has only the wholesale cost as presented by the detail man, and not the resale price. We, as pharmacists, would not inform any of your patients your charge for an office visit, for you wouldn't like that.

Another matter that would solve many problems for the pharmacist would be to receive prescriptions for generic terms of drugs or preparations instead of trade names. We would have a choice. Should we be running low on one specialty, we could use another brand, which would be identical.

We have no real grievances. Were we to single out any one and lay emphasis on it, we would place illegible prescription writing at the top of the list. We know you doctors are a very busy group of men and do not take time to write as legibly as you can. Sometimes a patient looks with awe and doubt when she hands her prescription to the pharmacist and may say "I don't see how you read that." With the present day potent drugs, an undotted "I" or an uncrossed "T" means, to us pharmacists, the difference between life and death. We do have trouble, sometimes, in deciphering the hieroglyphics of your prescriptions and to avoid any possible error we would suggest that you take a refresher course in penmanship, hire an amanuensis or buy yourself a typewriter, so your prescriptions will be unmistakably clear.

Indeed, we have no real differences—just a few minor irregularities, which can easily be corrected. Each of us has his own responsibility and that is the purpose of my appearing before you today. Please, consider this a little friendly chat to improve the now existing splendid relationship. If we have an exchange delegate attending eachother's convention each year — not particularly making speeches, but just attending,

milling around, rubbing shoulders, exchanging ideas, etc., this would go a long way towards a more complete understanding of the other's problems.

We feel that the physician needs the pharmacist for many reasons. Some of the better drug stores have a library for ready information when you call. The pharmacist has before him constantly new preparations, with their various dosage forms, physical appearance, incompatibilities, etc.; he invites your consultation.

Again, the physician needs the pharmacist for research, chemical analysis and other duties peculiar to the pharmacist. There is one thing for sure—the pharmacist cannot do without the services of the physician.

I appreciate the privilege of appearing before you and am grateful for your kind attention. Which brings me to the close of this little paper and reminds us of a man who was attending a Methodist Church. When the preacher had finished his sermon he said there would be a meeting of the board in the anteroom, just off the entrance, immediately after the service. The first man that he saw was the stranger who had attended the service and he said, "I don't believe I know your name?" The stranger said, "No, I am a stranger here but when you made the announcement that there would be a meeting of the bored I wanted to come and see if there was anybody anymore bored than I was." Thank you very much.

THE CHAIR: Now, gentlemen, we come to the part of the introduction of resolutions and recommendations. Those of you who have such I wish you would please give your names, and if it is a resolution, unless the whereas's, etc., have a lot to bear on the object of the thing, just read the "resolved part" of the resolution. I am ready and waiting and hopeful of some resolutions and recommendations now. Please use the microphone here in front when you make them.

Dr. Joseph I. Waring (Recognized)

DR. J. I. WARING: Is a proposed amendment to the Constitution and By-Laws in order?

THE CHAIR: Yes, come on up.

DR. WARING: This is not a matter of great moment but rather of convenience in getting the program prepared. We have in the By-Laws two items that seem to be more or less conflicting, (Reading) "Chapter 8, Section 15, requires that reports of Standing Committees and Special Committees shall be placed in the hands of a secretary sixty (60) days prior to the annual session of the House of Delegates, and in turn the secretary shall have these copied, and have them mailed to the delegates of the various component societies thirty (30) days prior to the meeting."

That has not been followed for a number of years; as you know the reports of the committees are now published in the *Journal* and I don't think any secretary has had the pleasure of mailing out reports to the delegates for some time.

Then a similar statement as to the program committee. Last year the By-Laws were amended so that the program committee was instructed to place in the hands of the Editor of the Journal—no, I beg your pardon, the Program Committee was instructed to provide the official program of the meeting thirty (30) days prior to each annual session.

These seem to be rather conflicting and I would like to offer an amendment which covers both of these provisions. An amendment or a substitute really for the section of the by-laws.

(Reading) "Reports of Standing Committees, Special Committees, the Executive Committee of the State Board of Health, the Benevolent Fund and similar organizations within the Association shall be sent to the Editor of the Journal at least sixty (60) days prior to the annual session of the House of Delegates, and shall be printed in that issue of the *Journal* which appears at a time closest to the date of the annual session. Reports which are not sent in by this required date may be subject to rejection by the House of Delegates."

The purpose of that is to avoid the roundabout provision in the first of these which says "to go to the secretary and then be sent to the members, and doesn't state anything at all about the *Journal*, and since the *Journal* is the important organ in getting these reports out I would like to offer that as a substitute to Chapter 8, Section 15.

Also, to change the Program Committee provision by stating "It shall be the responsibility of the Program Committee to place in the hands of the Editor of the Journal sixty (60) days prior to the date of the annual session a completed official program for publication in the *Journal*."

Sixty days sounds like a rather long time but with the slow processes we have to go through in producing the *Journal* it is very often close to missing the actual time of the meeting.

THE CHAIR: This resolution will be referred to the Constitution & By-Laws Reference Committee, Dr. McLane, Chairman.

Are there any further resolutions or recommendations? Dr. W. H. Hunter, Anderson County, recognized.

DR. W. H. HUNTER, Clemson, S. C.: "Resolution at a meeting of the Anderson County Medical Society held on April 10th, 1962. The following resolution was adopted by acclamation.

"Whereas state employees, with rare exception, are required to retire at age 65.

"Whereas capacity for useful and productive work is not necessarily related to this particular age, especially with increased expected longevity.

"Whereas such laws appear arbitrary without regards to individual competence.

"Whereas we believe such a retirement policy results in significant losses to the tax payer because of cost involved in training replacements, be it therefore Resolved:

"(1) That this Society ask those in authority to consider a retirement policy which would allow retention of those state employees who wish to remain gainfully employed after age 65.

"(2) That some procedure, including physical and psychological review, as well as vocational proficiency be instituted in order that eligibility for continued employment beyond age 65 may be ascertained for those that desire it.

"(3) That we cooperate in exploring such plans as may be evolved.

"(4) That this resolution be presented to the South Carolina Medical Association for consideration when it next convenes.

"(5) That copies of this resolution be furnished to the press and members of the 1963 General Assembly."

THE CHAIR: This resolution will be assigned to the Reference Committee on Legislation & Public Relations.

DR. WILLIAM HUNTER (Continues) "Resolution at a meeting of the Anderson County Medical Society held on April 10th, 1962. The following resolution was adopted by acclamation.

"Whereas the members of the Society here assembled recognize that automobile accidents are resulting in great loss of life and serious injuries to many people in our state; that in many cases, the life of an injured person may depend upon proper rescue operation and commitment of accident victims to the care of a professional medical team, be it therefore resolved:

"(1) That this society commend members of the South Carolina Highway Patrol for their efficient handling of wreck victims and rescue operations.

"(2) We join with all citizens in commending those responsible for the selection and training of patrolmen.

"(3) We register our concern in the gross inequities in pay scales for these outstanding public servants.

Therefore be it ordered, recorded and spread upon the minutes of this meeting that:

"(1) We acknowledge with appreciation the loyalty to duty exhibited by members of the highway patrol in making our highways safer for all citizens.

"(2) We recommend that efforts be made by responsible authorities to bring about substantial increases in salary for all members of the S. C. Highway Patrol.

"(3) Such other means for recognition of outstanding individual performance as may be proper be initiated.

"(4) That this resolution be presented to the South Carolina Medical Association for consideration when it next convenes.

"(5) That copies of this resolution be sent to the press and all members of the State Highway Commission, the Chief Highway Commissioner and to the head administrative officers of the S. C. Highway Patrol, and all members of the 1963 S. C. General Assembly."

THE CHAIR: I will assign this resolution to the Reference Committee on Miscellaneous Business, Dr. W. H. Williams, Chairman.

DR. WILLIAM HUNTER, Clemson, S. C. (Continues) "The Anderson County Medical Society on April 10, 1962, resolved that the South Carolina Medical Association approach the South Carolina General Assembly in regard to adding a law to the South Carolina Code, similar to the so-called "Good Samaritan Law" of the State of California."

THE CHAIR: That resolution, the third from Dr. Hunter of Anderson County, will be assigned to the Reference Committee on Legislation and Public Relations, Dr. P. K. Switzer, Jr., Union, Chairman. (Dr. Switzer did not answer) Dr. Cain, you are it. (Later Dr. S. O. Cantey was named and acted as Chairman of this Committee.)

Dr. Harold Pettit, Charleston, S. C. (Recognized).

DR. HAROLD S. PETTIT, Charleston, S. C.: (Reading) "Be it resolved that a standing committee on Mental Health Legislation be appointed by the president, and reappointed annually. It shall be the duty of the committee to review existing state laws concerning the mentally ill, to study new state and federal bills pertaining to the care of these patients, and to keep the members of the state association informed about the provisions and potentials of such legislation.

THE CHAIR: This resolution will be referred to the Reference Committee on Public & Industrial Health.

Dr. R. M. Anderson, Charleston, S. C., (Recognized)

DR. R. MAXWELL ANDERSON, Charleston, S. C.: (Reading) "Since we feel that further Federal control over care of the aged is another step towards socialized medicine, therefore:

"Be it resolved that the South Carolina Medical Association go on record as supporting the position of the American Medical Association as being opposed to the King-Anderson Bill now before Congress."

THE CHAIR: This resolution will be assigned to the Reference Committee on Legislation & Public Relations, Dr. Cantey.

Are there any further resolutions or recommendations?

Dr. Tom Parker, of Greenville (Recognized)

DR. THOMAS PARKER, Greenville, S. C.: (Dr. Parker explained standard forms used in the San Fernando Valley, where the doctors expect the patients to collect from whatever insurance company or whatever Government Agency they think ought to pay the expenses and then the patient pays the doctor.) They call this an individual responsibility program, they feel that it binds the patient and the doctor together more closely.

"I would like to resolve the South Carolina Medical Association to consider the adoption of an I. R. P. plan for South Carolina."

THE CHAIR: This resolution is assigned to the Reference Committee on Insurance, Blue Cross, Blue Shield.

Dr. Gressette (Recognized)

DR. JAMES H. GRESSETTE, Orangeburg, S. C.: I would like to propose that we amend the Constitution and By-Laws to increase the number of councilors from nine (9) to fifteen (15) for it to correspond to the new Judicial Districts of the State of South Carolina.

THE CHAIR: This will be assigned to the Reference Committee on Amendments to the Constitution and By-Laws, Dr. McLane, that is your baby.

Anything further, any further resolutions or recommendations? Bear in mind these will be before reference committees assigned as on the board here to places of meeting at the recess this afternoon. If you have anything to say for or against or sidewise, please make your appearance before these reference committees. If there are no other resolutions or recommendations I will ask Dr. Gressette and Dr. Ripon LaRoche to see if the ladies are on the outside. (The president of the Woman's Auxiliary, Mrs. John Cuttino, and Mrs. McMurry Wilkins, Jr., President-Elect of the Auxiliary were escorted to the platform.)

THE CHAIR: Ladies of the Woman's Auxiliary, I assure you it is quite a pleasure to have you here; I will ask you to come up, please. Gentlemen I would like to introduce Mrs. John Cuttino, the present president of the Woman's Auxiliary.

(Mrs. Cuttino gave a thumb-nail sketch of the accomplishments of the auxiliary, stating that the annual report would be published in the *Journal*, giving particulars of the year's work.)



THE CHAIR: Thank you, Mrs. Cuttino, for that splendid report and I am sure your fine report will be read by these men, with interest.

It is my pleasure to introduce Mrs. McMurry Wilkins,

Jr., of Greenville, the president-elect of the auxiliary. (Mrs. Wilkins stated the emphasis for the coming year would be on community service, which, she stated covered all phases of Auxiliary work, with legislation always at the top of the list. She closed by stating "As an auxiliary we are an arm of your organization, your problems are our problems and we are anxious to cooperate with you in every undertaking. We shall try at all times to be a service organization to and an educational force for the South Carolina Medical Association."

THE CHAIR: Thank you very much, Mrs. Wilkins, and ladies we appreciate your coming before us very much indeed, giving us your program for the past year and your hopes for the following year and we know and feel sure that both will be of great interest to us and we know that we can depend on your helping us carry some of the load on these legislative matters and things that are coming up from time to time. (Applause and House rises as the ladies leave).

THE CHAIR: We will start in with the report of the officers of this association. The president has made what report he deems necessary at the present time so, therefore, I will ask the Executive Secretary to come forward, please.

MR. JACK MEADORS: (Executive Secretary) (reading) President Wyatt, gentlemen of the house, Your Association during the past year has continued to experience steady growth and a successful operation. The year has been unusually free of problems. The matter of chief concern to the majority of the members has been and continues to be the King-Anderson Bill and the steady pressure on the part of its proponents to pass it at this session of Congress.

Since our last report we have had a net gain of 45 in membership, and this is in line with the average over the past several years. At present, the total membership stands at 1488, of which 130 are honorary, or exempt from the payment of dues; six who are likewise exempt because they are in service, and six Junior members who pay only $3.00 per year.

All but about 200 last year were, likewise, members of the American Medical Association. The increase in dues to the latter, effective January 1 of this year, has not seemed to have materially affected the number, although this may have influenced the payment of the so-called voluntary dues of $10.00 each to A.M.E.F. In 1962, to the present we have received dues to the State Association from 990, and to A.M.A. from 924.

Last year, 728 members paid a total of $7355.00 to the A.M.E.F.—a good half of the total membership, thus contributing. This year, so far, we have received only $3673.00 from 367 members, a little more than one-third of those who have paid State dues.

From a financial standpoint, we had a narrow margin of profit, but the value of the Association's investments have been materially increased. This, of course, is dealt with in detail in the report of the Treasurer, Dr. Stokes, and need not be repeated here.

Our State legislative session proved to be far less difficult this year than usual. One measure threatened to give us serious trouble—a bill similar to another two years ago to rewrite the osteopathic licensing law in such a way as to give the osteopaths the privilege of practicing medicine to the same extent as enjoyed by doctors under the Medical Practice Act. Continuing their effort from the end of the 1961 session, proponents tried very hard to have the bill introduced as a committee bill by the Senate Committee on Medical Affairs. When this failed, it was introduced by Senator Jessen of Dorchester County, and referred first to the Judiciary Committee, but was subsequently recalled, and referred to the Committee on Medical Affairs. We had been in touch with Senator Dennis, Chairman of that committee in advance, and at our request, a public hearing was held. Three of the few osteopaths in the State appeared and we accompanied Dr. Wyatt, Dr. Brewer, Dr. Gressette and Dr. Cain in representing the Association.

No action was taken by the Committee at the time but the bill was considered several weeks later, and despite a strong effort by a minority, was not reported out. In the last days of the session, a motion from the floor to recall the bill from the Committee was defeated and so the osteopathic effort failed completely.

Osteopathy is making a definite effort to improve its status throughout the country and is meeting with considerable success in some quarters. Its supporters will doubtless try again in South Carolina but we believe the line can be held.

Representative C. A. Mitchell of Oconee tried to have his Committee in the House sponsor a bill to license him as a physical therapist. We were able to stop this in committee without a great deal of difficulty, and he then turned his attention to chiropractic. After consultation with Association officials and the County Society in Oconee, it was agreed that this was not a measure of particular concern to the Medical Association. One chiropractor, more or less, in the State would have made little difference but the House Committee, on their own, turned thumbs down, and the bill was not even introduced. No doubt, the activity on the part of your Association in past years in discouraging such special legislation was, in part, at least, responsible.

The bill to require marking of blood taken for transfusion, as to its racial source, came very close to passage. Having been introduced the previous year, it passed third reading in the House on the first or second day of the session in 1962, went to the Senate, where it was referred to the Committee on Medical Affairs. Although we had been informed that the Committee would not report the bill out, unusual pressure by its proponents at the end of the session succeeded in having this done, and the bill passed second reading. On the next day, which was the final day for consideration of state-wide matters, a motion was made to re-commit the bill but this failed, and only the efforts of Senator Bristow, of Richland, in contesting the matter until the hour for final adjournment that afternoon, prevented its passage. While the bill was viewed unfavorably by Council, and we are sure by a majority of the members of the Association, no open, active opposition was conducted. Since the bill's author, Mr. Harrell, is not running for re-election, we are hopeful that it will not recur next year.

An act to provide for the creation of professional management associations was adopted. Similar legislation has been passed in a number of the states in the past year and a-half—the basic purpose being to enable doctors, lawyers, and other professional people to deduct from taxable income annually, limited amounts to create and maintain a fund for retirement income. Whether or not such legislation will have the desired effect remains to be seen. The state laws, possibly each one of them, will probably have to be tested in Court before there is anything definite on that.

A number of members of the Association expressed interest in this type legislation and, in fact, had called upon the Council and officers to sponsor it. Council decided against that, however, for several reasons. First, it was felt that such action might tend to compromise our traditional position against the corporate practice of medicine. Second, the effectiveness of such a law is in doubt and, third, we knew that banks, and other large interests in the State were sponsoring it and would probably be able to accomplish the passage without our activity. This proved to

be the case, and the statute is now in effect in South Carolina.

An analysis of the law will be made the subject of one of our Newsletters at an early date, so that members of the Association, who are so situated as to qualify, may determine whether they wish to avail themselves of its provisions.

We have cooperated with the American Medical Association in efforts against the King-Anderson Bill and are satisfied that a majority of the Congressional Delegation from South Carolina is still opposed to that measure.

About the usual meetings were attended during the year. In this connection, we cannot omit a reference to the Annual Meeting of the A.M.A. in New York last June, and the defeat of South Carolina in her intention to elect Dr. Julian Price, then Chairman of the A.M.A. Board of Trustees, as the President-elect of that organization. The circumstances of that unhappy and disillusioning experience were related in some detail in the *Journal* of your Association a short time later, for the record and for the information of the members of this organization. To our acquaintance with Dr. Price and his initiation of the Ten Point Program, we owe our connection with the S. C. Medical Association and the beginning of our nearly 18 years of pleasant relationship. It was a matter of keen personal regret and disappointment, that a man of his integrity, progressive attitude and genuine, sincere zeal for the welfare of his profession, should be denied the opportunity and honor of its national leadership.

Since the termination of your contract with the Federal Government on "Medicare" by action of this body in special session last Fall, payment by the Government for services to dependents of personnel of the armed forces has been continued through the agency of the Mutual Insurance Company of Omaha. So far as we know, this has proceeded satisfactorily and with a minimum of inconvenience and disagreement as to fees.

Preparation of the new Directory of Members has been completed, and we had hoped and planned for it to be mailed to you by the time of this meeting. Much careful and painstaking work was required, the final proofs checked and returned to the printer, and envelopes addressed. We are sure the Directory will be in your hands within the next two weeks.

Your attention is called to the Interstate Automotive Crash Injury Research program being conducted by Cornell University, with which we are co-operating, in line with approval given by this House a year ago. Letters are just going out from our office to doctors in the Pee Dee Area where the next survey will be made, beginning June 1st. This is the third section of the State to be studied for a six-months period. The undertaking is sponsored by the State Highway Department and State Board of Health, and with cooperation of the physicians in reporting on injuries, may contribute a great deal to the adoption of new safety devices in automobiles.

We call your attention also to the demonstration at the back of this hall, prepared by the Health Mobilization Division of the Civil Defense Agency, of the State. Also, to the scientific films presented by this Agency and thus furnished by the Accident Prevention Committee of the State, all of which will be shown in the T.V. Room throughout the meeting.

A large number of commercial exhibits attest the continued popularity of your meeting, particularly in view of the fact that it is one of four or five state meetings being held this week. Please give the exhibitors some of your time and interest and encourage the other members of the Association to do likewise. The hotel has been most cooperative in connection with all arrangements and we think the physical improvements made in the building since our last meeting here indicate their intention to further improve and maintain the status of the Ocean Forest as the outstanding convention hotel in the state.

Again, during the past year, we have enjoyed the full and friendly cooperation of the officers—Dr. Wyatt, President; Dr. John M. Brewer, Chairman of Council; Dr. Wilson, Secretary; and, of course, the Treasurer, Dr. Stokes, as well as all members of Council. It is indeed a pleasure to be associated with such a group.

Also, this report cannot be concluded without paying tribute to our loyal, efficient and hard-working staff at headquarters. For the amount and variety of work we carry on, their number is very limited and its success is made possible by their experience and devoted interest in carrying out their duties. The office is well-equipped with modern office machinery. This, of course, likewise contributes to the success of the operation. We look forward to a continued happy relationship.

Respectfully submitted
M. L. Meadors
Executive Secretary

THE CHAIR: That report will be referred to the Reference Committee on Reports of Council and Officers, Dr. Robert S. Solomon, Chairman. Is Dr. Solomon here? (no answer) Dr. Henry Ross, you are Chairman.

We will now hear from the Secretary, Dr. Robert Wilson.

DR. ROBERT WILSON, Charleston: Mr. President, Members of the House of Delegates, it has been my privilege to serve as Secretary of the South Carolina Medical Association for the past nine years and I would first of all wish to acknowledge my gratitude to the House of Delegates for this opportunity. During the past year there have been no unusual events of any sort and only routine matters have required attention.

The Secretary acts as the Secretary of Council and all meetings have been attended. The Secretary has charge of the Placement Service for physicians in the state and all such inquiries have been properly acknowledged. However, for this service to be of much value the Secretary is dependent on information from physicians in all parts of the state regarding their professional needs, and no such service is of much value unless the Secretary is kept apprized of this type of data.

The Secretary is the corresponding officer of the Association and it is his duty to inform the Governor's office of the various nominations by the Association for commission by the Governor. The American Medical Association is likewise informed officially of election as delegates and alternates, and various contracts made by the Association must be certfied by the Secretary. Many of the details of the work of this office are expedited by the Executive Secretary, and to him the Secretary is deeply indebted.

Again I would like to acknowledge to the House of Delegates my gratitude for the opportunity you have given me, and for this privilege I thank you all.

Signed Robert Wilson, M. D.

THE CHAIR: Thank you, Dr. Wilson, this report will be referred to the Reference Committee on Reports of Council and Officers, Dr. Ross, Chairman.

We will now hear from the Treasurer, Dr. Howard Stokes.

DR. HOWARD STOKES: Mr. President, members of the Association, the report of the Treasurer is contained primarily in the Audit prepared by Jaillette and Brunson and will be published in the *Journal of the South Carolina Medical Association.* The total revenue of the Association for the year 1961 was $123,491.98. The recorded expenses were $117,296.76.

This leaves an excess of revenue over expenses of $6,195.22.

These items are listed as follows:

Revenue:			
A. M. A. Dues		$32,586.75	
Membership Dues		35,437.50	
Subscription Dues		3,992.25	
A.M.E.F. Receipts		10,439.00	
Advertising		29,302.70	
Permanent Home Fund		6,567.50	
Miscellaneous Income		118.15	
Benevolence Fund		520.00	
Directory of Members		141.00	
Interest and Dividends		3,981.38	
Emblems		16.25	
County Dues		389.50	
Gross Revenue			$123,491.98
Less Expenses:			
A.M.A. Conventions		$ 2,179.22	
Dues and Subscriptions		219.40	
News Letter		197.46	
Insurance		967.20	
Office Supplies		1,036.53	
Journal		24,553.98	
Salaries:			
Editor	$ 3,000.00		
Executive Sec. & Counsel	10,000.00		
Secretary and Others	8,245.00	21,245.00	
Postage		587.00	
Telephone & Telegraph		2,701.43	
Travel Expense		2,365.47	
Audit and Legal		390.00	
Public Relations Expense & Conference		331.89	
Rent		1,100.00	
Taxes - Payroll		587.13	
Refunds and Transfers		727.46	
Miscellaneous Expense		1,370.30	
American Medical Education Foundation		15,942.75	
President's Office Expense		1,100.00	
Woman's Auxiliary		626.50	
Maternal Welfare Committee		200.00	
Historical Committee		500.00	
Committee on Infant & Child Health		114.39	
Woman's Auxiliary Bulletin		752.53	
Secretary's Office Expense		65.23	
Treasurer's Office Expense		100.00	
Committee on Public Relations		2,029.04	
Legislative Services		1,750.00	
Conference on Aging		77.65	
Benevolence Fund		1,490.00	
Directories		131.50	
A.M.A. Dues Remitted		31,857.50	
Total Expenses			$117,296.76
Excess of Revenue over Expenses			6,195.22

The Treasurer would like to remind the members of the State Association and especially the members of the House of Delegates that the amount stated as excess of Revenue over expense does not represent an up-to-the-moment picture of the financial situation. Actually the revenue for the State Association is derived from only four sources. First—the membership dues, including the subscription dues to the *Journal* amounted to $39,429.75. Advertising in the *Journal* totaled $29,302.70. Interest and dividends produced $3,981.38, miscellaneous income amounted to $654.40. Actual income for the Association for the year 1961 then was $74,235.69. Expenses concerned only with the affairs of the State Association totaled $71,269.05. So that the actual net profit for your association during the year 1961 amounted only to $2,966.64. This is in comparison to net income for 1960 of $16,067.23 and in 1959 of $16,351.00

Investments for the year included $6,465.00 earmarked for the Permanent Home Fund, as well as $12,500.00 for the general Association. This investment was made because of the relatively large balance on hand at the first of 1961 and because your investment committee believed it would be advantageous to invest as much as possible during the year. The investment of $12,500.00 required the "borrowing" of $5,000.00 from the Building and Loan Association which has subsequently been restored.

These last two investments bring to a total our investments of $100,820.93. It is worthy of note that without investment income which amounted to $3,988.00 our net loss for the year would have been $1,014.74. It therefore, must become quite obvious that our present Revenue without the investment income will not support the Association in its endeavors. Thank you.

Howard Stokes, Treas.

THE CHAIR: Thank you, Dr. Stokes, this report will be referred to the Reference Committee on Reports of Council and Officers. At this time I would like to hear from the Editor of the *Journal*, Dr. Joe Waring.

DR. JOE WARING, Charleston, S. C.: The *Journal* has survived the year under certain slight difficulties, and appears to be now in its usual state.

The first difficulty has been a reduction in income from advertising, a part of a nationwide trend which arose from the activities of Mr. Kefauver, the giant-killer of the pharmaceutical companies. There is now promise of a return to our older status as the Kefauver heat is reduced.

The second difficulty has been in the existence of an epidemic of writer's cramp over the State, resulting in a rather thin dribble of scientific material, and a rather frantic state of the editor's mind. There are some encouraging signs that the pen is swinging back into action, but slowly, and the lack of articles remains a perennial problem.

Nevertheless we carry on in the hope of being pounded with papers and covered with copy, a combination which might make an odd appearance for a desirable fool's paradise.

Signed J. I. Waring

THE CHAIR: Thank you Dr. Waring and we will ask him at this time to also give the report on Public Relations. The Editor's report on the *Journal* will be referred to the Reference Committee on Reports of Council and Officers.

DR. JOE WARING: The critical situation in which medicine now finds itself is an obvious reason for telling the true story of medical activities to a public whose view of the profession is increasingly distorted by the deliberate efforts of a hostile administration.

Our aim has been to try to replace an obvious, and sometimes expressed, apathy among many of our members with an active interest in telling our true aims and concerns to the public by way of our own medical voices. Formation of speakers bureaus has been encouraged and extended; presentations of television and radio programs have been arranged through interested county societies. Radio tapes have been made available with such speakers as Dr. Wyatt, Dr. Gressette, Mr. Dorn and Senator Thurmond.

Newspaper releases have been prepared and distributed. The affairs of this meeting have been announced and will be covered in the press.

These activities represent considerable time and work on the part of our public relations firm, Tobias & Co., of Charleston, working with your appointed representative and with county officers and committees

when opportunity could be made. My feeling is that their services have been of much value; results may be somewhat intangible, but I believe they exist in worthwhile amounts.

Services such as these are not inexpensive—experts cost money, and amateurs are not usually effective in this field. The question of how much we are willing to pay for these necessary services is now to be settled. That we are still in rather dire need of help is shown vividly by the fact that only three of our representatives in Congress have expressed their desire to oppose the King-Anderson Bill. The others are not audibly converted.

My feeling is that this effort is particularly timely and necessary. Council has suggested a sum not exceeding $5500.00 for this purpose. I believe it would be well spent. But please remember, that without the support of the county societies and many of you as willing individuals, the efforts of Tobias & Co., or any other company, will be wasted and futile. You and your colleagues are the real source of good public relations. A committee or a firm can only suggest and appeal.

Signed, J. I. Waring

THE CHAIR: This report on Public Relations will be referred to the Reference Committee on Legislation and Public Relations, Dr. Cantey, Chairman.

I would now like to hear from Chairman of Council Dr. John Brewer.

DR. JOHN BREWER, Kershaw, S. C.: Dr. Wyatt and Members of the South Carolina Medical Association, Council recommends to the House of Delegates that the committee on Accident Prevention be made a permanent committee of the Association; that this committee be composed of seven members as follows: (a) The Chairman of the Committee on Accident Prevention of the S. C. Chapter of the American Academy of Pediatrics; (b) Six other members of the Committee, two appointed for a one year term, two appointed for a two year term, and two for a three year term, with subsequent appointments for three years; that the function of this committee be to make recommendations in the spheres of education both to the medical profession and to the general public, cooperation after consultation with Council, with the South Carolina Highway Department, the South Carolina Industrial Commission, Civil Defense, and the Health Insurance Council; cooperation with the Advisory Committte to the Maternal and Child Health Division of the South Carolina State Board of Health in its accident prevention program, and the development and recommendation, after approval by Council, of accident prevention legislation to the State Legislative Committee of the South Carolina Medical Association; all activities of this committee to be subject to the approval of Council before action might be taken in any of the spheres of its activity.

Council further authorized the present committee to function in this capacity, subject to the approval of Council before action may be taken, until the next meeting of the House of Delegates.

(1) Public relations—Council recommends that this committee be continued under the chairmanship of Dr. Joseph I. Waring at an expense not to exceed $5500.00 per year.

(2) Council directed Dr. Charles Wyatt, President of the South Carolina Medical Association to send a telegram to all three candidates of the United States Senate asking for their stand on the King-Anderson Bill.

(3) Council ordered the chairman to appoint a Committee to study Medical Education. This liaison committee also to study all state agencies having Medical Advisory Committees.

THE CHAIR: This report, gentlemen, will be referred to the Reference Committee on Reports of Council and Officers, Dr. Ross, Chairman.

We will now have the report of the Delegate to the A.M.A., Dr. George Dean Johnson.

DR. GEORGE DEAN JOHNSON, Spartanburg, S. C.: Mr. President, members of the House of Delegates, I would like to say a few words about our failure to nominate Julian Price as president of the A.M.A. It came as a great shock to all of us to see a man who was dedicated to his work and who had spent eight years tirelessly working for the benefit of American medicine to be kicked in the teeth the way he was. There isn't any use to re-hash what has happened, we know that there were a few men that he had antagonized by his forthrightness and they had in their pockets the votes of some of the larger delegations. The same people who last year accused Julian of being a "compromiser"—when they found that didn't work they turned and called him a "dictator". Julian had been out of the house for eight years, not many members of the house knew him. We couldn't figure any way on earth to stop the rumors and misstatements of fact that were going around and I am sure that we were all as upset as Jack Meadors or anyone else concerned could be.

Julian was hurt but the loss of the nomination of president-elect was not what hurt him as much as the friends, former friends, he had passed in the hall who refused to speak to him. I think that hurt him more than anything else. He had many friends, all who voted for him—all of the southern states, with the exception of Florida, and half of Mississippi voted for him; New England voted for him. He received only two (2) votes west of the Mississippi.

Fount Richardson, who was a good friend of Julian's, and president-elect of the Southern Medical Association, voted for him, I know, and Dr. Willard Wright of North Dakota voted for him.

We have been accused of dereliction of our obligation by not having a party for him. Julian didn't want a party. The man who preceded him didn't have a party, the man who beat him didn't have a party. I think it is one of those meetings of circumstances where the man was in the right place but at the wrong time.

I think it was a loss to American medicine.

All you surgeons, who are members of the American College of Surgeons will probably meet in Chicago in June. They have rented the largest hall available; I am told it will seat 5000 people, where you will thrash out whether you want the abdominal surgeons to form a separate organization or not. I have a feeling, that I can't verify, that the autocracy of the College of Surgeons is finally coming home to roost.

I would like to say a few words about "original jurisdiction", because it is one of the things that has been hanging fire in the American Medical Association House of Delegates for two years. I believe it will be settled this year to the satisfaction of everyone. Heretofore they have always had the right of original jurisdiction, that is, if South Carolina didn't do anything to a member and A.M.A. thought something should be done—and, of course, the only thing the A.M.A. can do is take away the A.M.A. membership—they could do it, however, the legal department of the A.M.A. felt that it was not fair enough. Original jurisdiction will be used only in the following circumstances,—where a state has already exercised its right of recall of membership or where a state gives consent for A.M.A. to come in, or where a state makes a request for the A.M.A. to come in. In other words, the A.M.A. is not coming into South Carolina to tell you and me what to do—after all, the A.M.A. is all of us here and just like this group all over the nation. It is a separate group of doctors

that are practicing somewhere outside of the states where you and I live.

I would like to announce that for pastime we will have a hospitality room in conjunction with Tennessee, Virginia, North Carolina, Georgia and Alabama. This will be in rooms 738-739 of the Palmer House, and we hope all of you who are there will stop by.

Someone has wondered why Medicare has refused to publish its schedule of fees. This was done for the simple reason that where a schedule of fees is not published the cost to the Government is about twenty (20%) per cent less. If you don't have a schedule of fees, send in your regular fee and you will probably be paid.

As you know the American Medical Political Action Committee has been formed under auspices separate from those of the A.M.A., and it is called AMPAC. If you wish to contribute money to the defeat of people who are against medicine that you and I approve of, please send in your donations to it.

There has been an increase in dues, as you know, and most of that money is going to set up loan funds for medical students. And you know for every $100,000.00 you and I put up—students may borrow twelve times that much.

Someone has talked about public relations; in this section of the country with few exceptions we get very little idea of how the rest of the nation feels. It will give you a strange feeling. If you read the editorial page and will cut out some of the editorials or some of the cartoons and send to your paper you will help brain-wash the editor as he is being brain-washed from information from APW. In our paper at home we have found that very effective. He does not always repeat what we send him but at least he knows that we are interested and when I pass him on the street he thanks me for sending it to him and I am sure that your editor will appreciate your sending it to him. The grass roots is where the King-Anderson Bill will be defeated, not in the halls of the doctors. I appreciate very much your allowing me to serve you as one of the delegates to A.M.A. I come up for re-election this year and I would appreciate your sending me back, if you see fit. Thank you.

THE CHAIR: This will be referred to the reports of the Officers and Council. And I will now ask Dr. Weston, our other delegate to the A.M.A., for his report.

DR. WILLIAM WESTON, JR., Columbia, S. C. Mr. President, officers, past-presidents, and delegates, Ladies and gentlemen (Reading) Report of Delegate to the A.M.A., June, 1962, will be the first time in 24 years that a William Weston will not be accounted for as a delegate to the A.M.A. My father, Dr. William Weston, represented the Pediatric Section of the A.M.A. from 1938 to 1951 and I was your delegate from 1951 through 1961.

You are fully aware how much most of us abhor socialized medicine. The Murray-Dingle Bill was defeated. We fought to squash the Forand Bill. We sponsored the Kerr-Mills Bill, which passed and has been running smoothly in South Carolina for the past two years, that is, state funds matching federal funds to take care of our indigent aged. We now must join hands to resist with our full impact to defeat the Kennedy-Ribicoff King-Anderson Bill—a measure to increase social security tax in order to insure every one 65 and older, medical care, drug bills and hospitalization. Can't you understand this is the government wedge into socialized medicine? I urge you to support the Blue Cross-Blue Shield organizations (which are non profit) sharing in taking care of these individuals past 65 years of age. Approximately 33% of these people do not wish it as they are already covered and a minimum of 43% or more can afford the nine to twelve dollars a month costs of Blue Cross and Blue Shield. There will be only about twenty (20%) per cent who need the Mills-Kerr aid.

This brings us to social security which in the beginning was a misnomer. There are several state medical associations such as New York, Massachusetts, New Jersey and, I believe, Maryland which have endorsed it. If you, as a doctor, have reached the age of 65 years then it will pay you but I address my remarks here particularly to the young doctors. There is no insurance existing or that will be propounded that a private Insurance Company can not do better and cheaper than the U. S. Government. Put enough aside to protect your family and have some for a nest egg when you reach 65 but don't put all your savings in one place for there are Building and Loan Companies, Stocks and Bonds and Land, city and county real estate. Over several years ago, I spoke in a reference committee at the A.M.A., against Social Security at which time I described Social Security as a cake covered with beautiful icing, but the icing consisted of uric acid crystals.

Two years ago a measure was introduced in the house of delegates condemning tobacco as a cause of cancer. I spoke against it saying the tobacco leaf was exposed to the wonderful elements of nature—sunshine, oxygen, nitrogen and water, while beets flourished from manure contact and the sugar manufactured from same would be contaminated. You have heard a lot about that, since then.

The Use of Tobacco & Relations to Diseases

The National Institution of Research and many independent investigators are now undertaking this work so the Board of Trustees held that the American Medical Association was not the body to undertake this investigation. The reference committee upheld this view and was approved by the House of Delegates.

The American Medical Association and The American Bar Association are working harmoniously together smoothing out the complaints and difficulties. As Dr. Johnson just told you the A.M.A. dues have increased $20.00, $10.00 this year and $10.00 next year, thus totaling $45.00.

You should know that the office of the Assistant Secretary of Defense (Health & Medical) was abolished and its function transferred to a lay person (page 34, Proceeding of the House of Delegates.)

Dr. Walter H. Judd (Congressman) from Minnesota received the Distinguished Service Award. (I hope we have a congressman from S. C. this year who is a doctor.)

The automobile manufacturers were commended for having seat belts on the front seats of all motor vehicles automobiles built in this country in 1962.

The AMA Positive Ten Point Program

1. Costs of Medical Care
2. Voluntary health insurance and prepayment
3. Help to the needy and near-needy aged
4. Health of the aged
5. Mental health
6. Physician supply
7. Continuing education and research
8. International health
9. Preservation of the freedom of patients and physicians
10. Health and Safety Education

Relation of Medicine to Optometry

The medical doctor does not consult on the eye with others than M.D.'s.

Group Annuity or Retirement and Group Disability Insurance

Retirement Medical Insurance has been placed in

the hands of the State Medical Association and specialty groups.

Medical Disciplinary Committee

Medical Disciplinary Committee has done an excellent job to which Dr. Harold E. Jervey contributed considerable work and suggestions. I recommend that each delegate here assembled read and discuss the entire proceedings.

Polio

The House of Delegates in the June Session, 1961, approved the Sabin vaccination which is poliomyelitis vaccine per os. It is necessary to give this vaccine *en masse;* otherwise, it is considered dangerous, as it can be passed from the individual receiving the inoculation to those that are not immune. I did not think that this was in good taste nor good judgment and I expressed my opinion in this manner to the House and the Vice-Speaker. My reasons were that we had sponsored the Salk Vaccine in 1956 and the House of Delegates had never approved of same, that is to the best of my memory. Perhaps some of you can recall the use of cold vaccine per os and the typhoid per os, and both have been discarded.

My responsibilities as a delegate were always carried out to the best of my ability and I hope for the best interest of the doctors in South Carolina. The larger states entertain a great deal, such as: New York, California, Pennsylvania, Illinois, Michigan, while others as groups got together for this purpose.

Then there is the Aces and Deuces which was organized by Julian P. Price to which South Carolina belongs. The social functions are fun but one must be careful in accepting them from drug houses, else they will expect something in return.

Now, there has been established the A.M.E.F. for the past five years which is skyrocketing and I can't mention this without passing an orchid to our R. L. Crawford who did a wonderful job in its infancy.

The A.M.P.A.C. was organized this past year and I request that you join in sending your contribution to The American Medican Political Activity Committees. You must fight fire with water and we need every ounce to douse the antimedical and socialized medical bills.

The latest action which the A.M.A. has taken is largely due to the S.A.M.A. (students) and a resolution which I introduced the past two years which was notably backed by Dr. Ed Compere, that is setting up a loan fund for students, internes, and residents. The first one hundred thousand dollars is to be matched by Merck, Sharpe & Dohme Company.*

Let's call it the S.I.R.F. If you believe in the future of your profession, you will contribute—I have.

Now that you have chosen to have someone else succeed me, I hope for him nothing but success and God speed. I appreciate the opportunity of being one of your representatives this past decade.

Thanks for listening.

William Weston, Jr., M. D.

THE CHAIR: Thank you, Dr. Weston, that report will be assigned to the Reference Committee on Reports of Council and Officers, Dr. Ross, Chairman.

THE CHAIR: And now, we have come to the "Special Order" of the afternoon—The Annual Meeting of the Corporation, The South Carolina Medical Care Plan. I will ask Dr. John Siegling if he would please take over the meeting. Gentlemen, I ask you all to stay because there has been some complaint about not knowing what is going on, and it is your organization and it is up to you to see what they are doing. Dr. Siegling.

*It has already been matched because it is nearly a million dollars.

(SPECIAL ORDER)
The Annual Meeting of the Corporation
The S. C. Medical Care Plan.
Presiding, Dr. John Arthur Siegling

DR. SIEGLING: Dr. Wyatt, gentlemen, I now declare the Annual Meeting of the Corporation of the South Carolina Medical Care Plan in session.

The minutes of our last annual meeting were published in the *Journal* and I shall not have them read unless someone desires the minutes to be read. Hearing no voice I shall proceed with the order of business.

President's Report.

I am pleased to report to you that your Blue Shield Plan has had an outstanding year. The total income from Blue Shield contracts during 1961 was $2,036,-991.00. Of this amount $80.8%, or $1,646,519.00, was paid to physicians.

The life blood of the Plan is its membership. During 1961 total membership in the plan rose to 204,584, a gain of 15,757 members or 8.3%, over 1960. This represents only about 8% of the citizens of South Carolina, so that there is still room for improvement. During the year the Federal Employees' Program also increased, rising from 35,329 to 38,514.

It is obvious that physicians of the state are becoming increasingly aware of the fact that this is their plan. Participating physicians increased from 1232 in 1960 to 1420 as of January 1962. This represents 85% of the physicians of South Carolina, a percentage which is also the national average. Bob Tomlin is doing an excellent job in ironing out problems between the Plan and the doctors and you are urged to call on him if you have any problems.

The chief business of this meeting today will be action upon the proposed plan to participate in the National Blue Shield Senior Citizen Contract, of which you have been made aware in the press.

Now, I would like to explain this to you in a thumbnail sort of way and I hope that we will not go too much into dollar values in individual items. First of all this program has been engendered to some extent and certainly fostered by the American Medical Association House of Delegates and, in conjunction with Blue Shield Plans the country over and the National Blue Shield Plan, they have come up with a Plan to voluntarily, on the part of people, cover all persons over 65 years of age. This is a realistic program to cover elderly persons in our nation and it has received enthusiastic response from the press of the nation to the point where to some extent, I think, the administration and Mr. Ribicoff have been set just a little bit back on their haunches with the idea that medicine could at least to some extent foster a program to take care of our senior citizens.

The contract calls for the Service benefit care of an individual whose income is less than $2500.00 and married persons with a combined income of under $4000.00. Benefits must be uniform nation-wide, and the uniformity has been worked out based on what is called a National Professional Service Index. As you know in our own plan we have a professional service index which gives a certain unit value to every procedure that can be done physically, and actuaries have worked out a uniform plan by combining and correlating all plans in the nation and working out what is called a national professional service index which is cataloged in a book which gives every index number.

(At this point Dr. Siegling gave a resume of the program, going over it item by item.)

This plan will be a part of every Blue Shield Plan in the nation, and will represent a National Program of direct-pay subscribers completely independent of Blue Cross. The benefits will be uniform nationwide and the experience will be accumulated on a national

basis. The unit values allowed have been reached by making a composite of values from all Plans in the country and acquiring an average.

Your board of Directors has studied the Plan carefully and believes that it should be endorsed, not only as organized medicine's answer to care of persons over 65, but also as a very reasonable counter-proposal to the King-Anderson Bill. After consideration, your Board recommends participation in this program at the National unit values already accepted by most of the states, and recommends the following dollar values:

Surgery	$2.50
Anesthesia	2.50
Radiation therapy	3.00
Diagnostic x-ray	3.00
In-hospital medical	1.25
In-hospital intensive med.	1.25
Nursing home care	1.25
Lab. and pathological serv.	3.00

The action of the Board has been confirmed by Council, and Council recommends implementation of the Program. Please be assured that all of your representatives on the Board and in your Council have carefully studied the Program and endorse it.

In view of this I shall entertain a motion from the floor at this time that the Corporation endorse the plan and desire implementation of it. I shall entertain a motion that your Blue Shield Plan be empowered to implement the program as outlined to you.

DR. GEORGE DEAN JOHNSON: I so move. (This was seconded by Dr. Owens of Columbia. This motion was passed without discussion unanimously.)

THE CHAIR: I want to tell you that I consider this a very considerable vote on your part of the Board that has been carrying on this Plan and let you know that we appreciate your cooperation. But I can't let this time pass without expressing appreciation for the valuable assistance of members of the Board, both lay and professional. They have discharged their duties faithfully, and have given at least four days each year to the business of the Board. Special thanks are due Dr. Wyman King, who has served on the Board since its inception and given 14 years to this work.

Dr. King has asked that his name not be placed in nomination for continued service, and the terms of several other members of the Board have expired. I would like to call on Dr. John Brewer, Chairman of Council to read Council's list of nominees for membership on the Blue Shield Board. DR. BREWER: (Election of Board members)

DR. JOHN BREWER: Dr. Siegling, members of the South Carolina Medical Association, the names that have been proposed by the nominating committee of the South Carolina Medical Care Plan are as follows:

Mr. Frank S. Adams
Mr. Wilton F. May
Mr. M. L. Meadors
Dr. J. A. Siegling
Dr. W. W. Simmons
Dr. Joseph Cain

THE CHAIR: Do I hear a motion of approval of these or would you like to vote on them separately? (Motion was made by Dr. Prioleau that the slate be voted on as a whole, seconded by Dr. Propst, there was no discussion, the vote was taken and passed and it was so ordered.)

THE CHAIR: At this time I want to thank Mr. Sandow and his staff, Mr. Dave Dick, Sales Manager; Con Starin, accountant; John Alexander, office manager; and all the other staff members for their excellent work during the year. You will be interested and proud, I know, to hear that our Executive Director, Mr. Sandow, was elected Treasurer of the National Blue Shield Plans last month. Mr. Sandow is here and I would like Mr. Sandow to express any views he has to you at this time. Mr. Sandow. (Applause)

MR. SANDOW: Thank you Dr. Siegling, I have no formal report, as such. My past experience has been that quite generally the degrees to which the Blue Shield Plan seems to be successfully operating is somewhat in inverse proportion to the amount that I feel compelled to say at the annual meeting. So, I find that by keeping it brief things are running along, I think, pretty well.

Dr. Siegling has hit the high points of the year's activities. I think we have had a substantial but for us very satisfactory growth, as far as membership is concerned. The plan is stable financially and in good financial condition. We have received complete approval of the insurance department and our own auditor. I think as far as the future is concerned, we will continue to try and do better the same job that we have always been trying to do and that is to encompass more and more people under the coverage of the Blue Shield Plan on more comprehensive benefits and we hope at higher fee schedules. And the degree to which we can succeed in doing that, I think, we will also succeed in preventing further government intrusion into the whole spectrum of medical care because the government cannot and will not be inclined to intrude itself where a vacuum does not exist, and I think for too long we let a vacuum exist as far as the old age people are concerned. Now, we are faced with the problem of trying to do something in a hurry and unfortunately, as far as the Washington situation is concerned, the time is short, at least as far as the hospital end of it and the King-Anderson Bill is concerned. The degree to which we can prevent this thing happening is a very questionable item at the moment. From all appearances the President, Mr. Kennedy is going to make a closed television circuit address, later on this month, to a large gathering of senior citizens in Madison Square Garden and indications are that this is to be the kick-off of the final drive on the part of the administration to put something in the form of the King-Anderson Bill through. I think it is really a questionable item as to what the outcome is going to be. This I do know that unless we continue to really make progress, in terms of more and better coverage for more people, we are going to be continually faced with this further and further encroachment.

It has certainly been pleasurable to have worked with and for you during the past year and over the past years. I thank all of you for your cooperation and help and I can assure you that we will continue to do the best that we can for you and we cannot do it without your support. Thank you very much.

THE CHAIR: Thank you Mr. Sandow.

I would like to say that it seems to me that doctors in South Carolina, and really the nation over now, are sold on the ideology of Blue Shield and I really do think that we have an unparalleled opportunity to sell our patients on Blue Shield and it will certainly help the sales force and the executive of the Plan if we will make every effort we can upon every opportunity we have to sell our patients on the importance of coverage, voluntary coverage, particularly under Blue Shield.

In conclusion, let me thank you also for your cooperation with the Plan during the past year. Those of us who are actively carrying on the work of the Plan are convinced of its importance, and ask that you believe with us that it is the best bulwark against Federal medicine.

Now, is there any further business to come before this meeting, any further business? If not, I would like to turn the meeting back over to Dr. Wyatt.

(Conclusion of Special Order.)

CONTINUATION OF MEETING OF HOUSE OF DELEGATES, S. C. Medical Assn. Dr. Charles N. Wyatt, Presiding:

THE CHAIR: Thank you Dr. Siegling and Mr. Sandow. We hope that the members of the House of Delegates will take note of the changes in this new plan that the Blue Shield Board has entered in.

At this time I would like to recognize Dr. Green of Columbia. Will you come up?

DR. JAMES T. GREEN, Columbia, S. C.: Mr. President, Members of the House of Delegates of the South Carolina Medical Association, it gives me great pleasure to announce to you officially that we have Dr. Frank Owens running for Congress from the second Congressional District. The Medical Association will now have the opportunity to have a representative in Congress, which has terrific import. There are many bills in the Congress of the United States and I think there are numbered around 16 that pertain to the health of the people, veterans, research, medical students, etc., and certainly we need another doctor in Congress who can handle these things. The services there will be invaluable. At the present time there are six doctors in Congress and there are 245 lawyers. Dr. Frank Owens is a general practitioner in Columbia, as you all know; he is willing to give up a very fine practice to run for Congress from the Second Congressional District; he has had much previous experience in Government. He has been the Mayor of Columbia, S. C., for a period of four years and did a fine job; he was in the United States Air Force, he is a past president of the Columbia Medical Society and has been chairman of many committees and is still chairman of many important committees, particularly pertaining to legislation. Since I have been president of the Columbia Medical Society he has worked tirelessly on many committees, has arranged many things that have been very helpful to the Columbia Medical Society. One thing I did not mention before is that he has been in charge of the Committee on Selective Service for the State of South Carolina and has done a magnificient job. To my personal knowledge he is opposed to the King-Anderson Bill and the Forand-type of legislation. The importance of putting another doctor in the United States Congress not only affects us here in the South Carolina Medical Association but affects all doctors everywhere. It is certainly my recommendation that all those who can, render whatever effort they can and particularly those men in the second Congressional District. Thank you.

THE CHAIR: We will now have Committee Reports; they will be found in the April 1962 issue of the *Journal* beginning at Page 138.

The Committee on Legislation and Public Relations. This report will be assigned to the Reference Committee on Legislation and Public Relations and do they have any further report? (There was none)

COMMITTEE REPORTS:

The Medical advisory Committee to Selective Service, do you have any further report? (Dr. Owens stated no further report.) It will be assigned to the Reference Committee on Miscellaneous Business.

The Committee on Infant & Child Welfare and Child Health? They have a report and supplementary report, do you have anything further? (Nothing further) This report will be assigned to the Reference Committee on Public & Industrial health.

The Committee on "Care of the Aging" do you have anything further in your report? (There was no answer) Hearing none this will be referred to the Reference Committe on Public & Industrial Health.

The Report of the Committee on Cancer, do you have any further report? Hearing none this will be assigned to the Miscellaneous Business Reference Committee.

The Committee on Study of current efforts of A.M.A. along Public Relations line, Dr. Waring, do you have anything further? (Nothing further) That will be assigned to the Reference Committee on Legislation and Public Relations.

The Medical Advisory Committee to the Crippled Children's Society of South Carolina, any further report? Dr. Waring is recognized by the Chair.

DR. WARING: Since the report was made up in the *Journal,* there has been a meeting of this Committee in Columbia recently, considering a situation that arose, in Charleston, where the local chapter of the Crippled Children's Society was planning to build a rehabilitation center. This has met with a lot of opposition in certain quarters and for a time it seemed as if the project might be defeated. I might say that the committee was unanimous in agreeing that it should proceed with the original plan without any change.

THE CHAIR: This report will be referred to the Miscellaneous Committee.

The Liaison Committee, is there anything further to report? Hearing nothing this report is referred to the Miscellaneous Committee.

The Committee to Study Injuries from Lead Pellets, Dr. Jervey, do you have anything further to report. (There was no further report) This will be referred to the reference committee Public & Industrial Health Committee.

The Committee on Historical Medicine, anything further? This will be referred to the Reference Committee on Miscellaneous Business.

The Committee on Liaison with Allied Professions, is there anything further? This will be referred to the Reference Committee on Miscellaneous Business.

The Committee on School Health, anything further Dr. Paul? If not this will be referred to the Reference Committee on Public & Industrial Health.

The Committee on Womans' Auxiliary to the Medical Profession, is there anything further, Dr. Hanckel? Since there is no further report this will be referred to the Reference Committee on Miscellaneous Business.

The Committee on Rehabilitation, Dr. Miller, anything further? Hearing nothing it will be referred to the Reference Committee on Miscellaneous Business.

The Committee on Industrial Medicine, Dr. Smith is here, is there anything further from your committee? Hearing nothing it will be referred to the Reference Committee on Public & Industrial Health.

The Committee on Accident Prevention, is there anything further from that committee, Dr. Moore? Hearing none it will be referred to the Reference Committee on Public & Industrial Health.

The Committee on Coroners-Medical Examiner, anything further? If not it will be referred to the Reference Committee on Legislation and Public Relations.

The American Medical Education Foundation Committee, Dr. Stokes is there anything further? If not this will be referred to the Reference Committee on Miscellaneous Business.

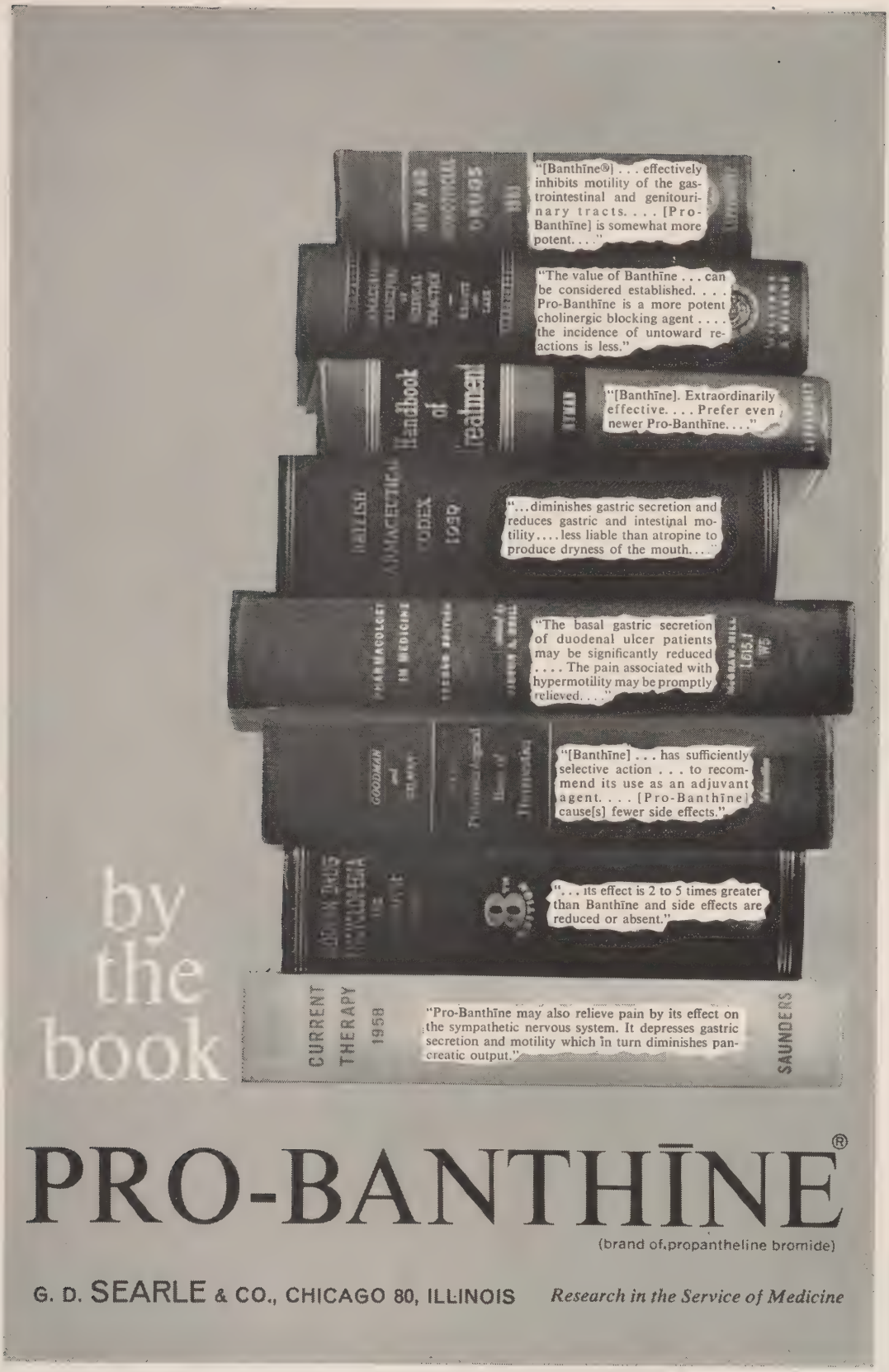
The Committee on Medical & Hospital Insurance Contracts, is there anything further? Hearing none this will be referred to the Reference Committee on Insurance, Blue Cross, Blue Shield.

The Committee on Disaster Medical Care, they have a supplemental report which will be given to this Reference Committee, and that will be referred to the Reference Committee on Miscellaneous Business.

The Committee on Maternal Health, anything further, Dr. Dennis? Hearing none, this will be referred to the Reference Committee on Public & Industrial Health.

The Benevolence Fund, anything further, Dr. Billy Smith? Hearing none this will be referred to the Reference Committee on Miscellaneous Business.

The Committee on Rural Health, is there anything further. If not, this will be referred to the Reference


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Committee on Public and Industrial Health.
The Executive Committee Report of the State Board of Health, is there anything further, Dr. Wallace? (Dr. Wallace stated nothing further.) This will be referred to the Reference Committee on Public & Industrial Health.
The Report of the Program Committee is manifest by the program that you have in your possession at the present time. I hope that you will be here to enjoy this, it looks like it is going to be very good.
The Report of the Memorial Committee will be given at the breakfast at 7:45 on Thursday morning.
Are there any other resolutions, recommendations or reports that I have missed?
Dr. William H. Hunter, of Anderson: Mr. President. (THE CHAIR RECOGNIZES DR. HUNTER.)
I have a resolution of my own I would like to bring up, and I think that at the present if possible, or in the future—when political activities are brought up on the floor, perhaps both parties should be allotted equal time.
THE CHAIR: Do you have a candidate for the Second Congressional District, Dr. Hunter?
DR. HUNTER: No, sir, I do not have a candidate, personally.
THE CHAIR: Then I rule you are out of order. Is there anything further?
DR. C. T. WESTON: I would like to make an announcement.
THE CHAIR :All right.
DR. WESTON: Our candidate for the United States Senate, Mr. W. D. Workman will be here all day tomorrow in Room 314, and I would like for you all to come by and meet him and talk with him.
DR. OWENS (Recognized by the Chair): This is not a political announcement. We heard the fine report of Blue Cross-Blue Shield, is that being referred to any committee? Is the society going to take action and recommend that report?
THE CHAIR: My belief on that, Dr. Owens is that it was adopted by the Corporation in session. This House of Delegates acted as the Corporation.
DR. OWENS: I just wondered if the society as a whole should make that recommendation?
THE CHAIR: Is Jack Meadors in the house? (no answer) What is the policy on that?
DR. CAIN: I think in accepting it as a Corporation, they are both the same, and in accepting it as a Corporation we are accepting it.
THE CHAIR: That was my opinion and understanding.
Dr. Hunter, I didn't mean to be short and snappy with you, sir. The first thing, I didn't know this matter was coming up at this time; secondly, I allowed this because we do have an adopted candidate, a member of our association, and thirdly, I was not aware and still am not aware that you had a candidate running in this particular race.
DR. HUNTER: I would like to say that in the Second Congressional District this year the election will not be determined in June but will be determined in November and we hope to nominate a very fine young man from the second district, he is _____
THE CHAIR: (Interrupting) But he has not been nominated yet?
DR. HUNTER: No, he has not been nominated.
THE CHAIR: That was my ruling, I did not mean to throw you any curve. Is there anything further?
Dr. Wilkinson, we will have your report from your Board of Medical Examiners.
DR. WILKINSON, (Recognized) Mr. Chairman, Fellow members of the House of Delegates, I have a very brief report:

BOARD REPORT FOR 1961.

The State Board of Medical Examiners met: April 26, June 26, 27, 28; November 7, 8, of 1961.
In 1961 the Board licensed 78 physicians by written examination and 35 physicians by endorsement of credentials. During the year 88 temporary certificates were issued. There were 57 physicians certified to other states.
In 1961 twelve disciplinary cases were heard by the Board, some of these were reports following previous hearings. One license was revoked, the revocation suspended, and the physician placed on probation for a period of five years.
The Board now issues an official directory. Since the Board receives no appropriation from the state government, a charge must be made for this service.
Something I want to call your attention to particularly, I have been called, referring to this problem. The Board of Medical Examiners, as now constituted is illegal. The illegality coming from the fact that two board members are also state officers in other realms. I don't know what you want to do about it. I am up for re-election and it may not be one of my worries, but we have two men who are public officers and I am advised by the Attorney General that this constitutes two offices, entirely separate and distinct, which is against the state law.
Any action the Board instigates by trial, revoking of licensure, etc., could be attacked legally on this ground.
I will leave that with the House of Delegates and you can do about it as you "damn" please. But I don't like to bring this matter up because these two gentlemen are very able and dedicated people to this work. However, dual office holding in the State of South Carolina is still illegal.
One other matter I would like to bring before you for one second and that is that anytime that you are ready to have a different type of licensure affair picked up in the way of a voluntary re-registration, the Board is willing to carry out your wishes, but the Board is not going to propagandize anything.
THE CHAIR: Gentlemen, you have heard the recommendation of the Board of Medical Examiners, what is your wish in regard to this report?
DELEGATE: Send it to a reference committee.
THE CHAIR: All right, recommendation has been made that it be sent to a reference committee, do I hear any objection to this? Hearing none, I will assign this to the Reference Committee on Reports of Council and Officers.
Is there anything further from the State Board of Health?
DR. WALLACE: Nothing further.
THE CHAIR: Is there anything further, gentlemen? Any New Business? If not, I declare this House of Delegates recessed until 9:30 tomorrow morning. (Recessed)

MINUTES TO BE CONTINUED IN THE NEXT ISSUE.

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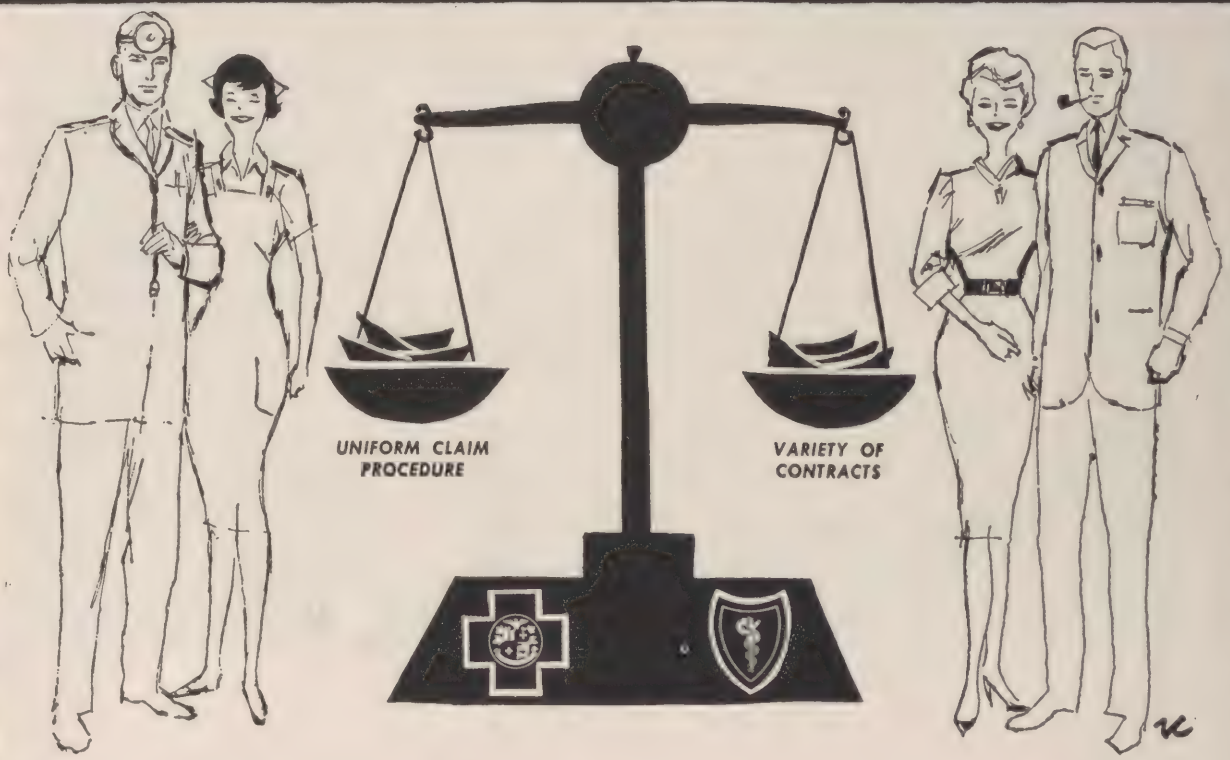
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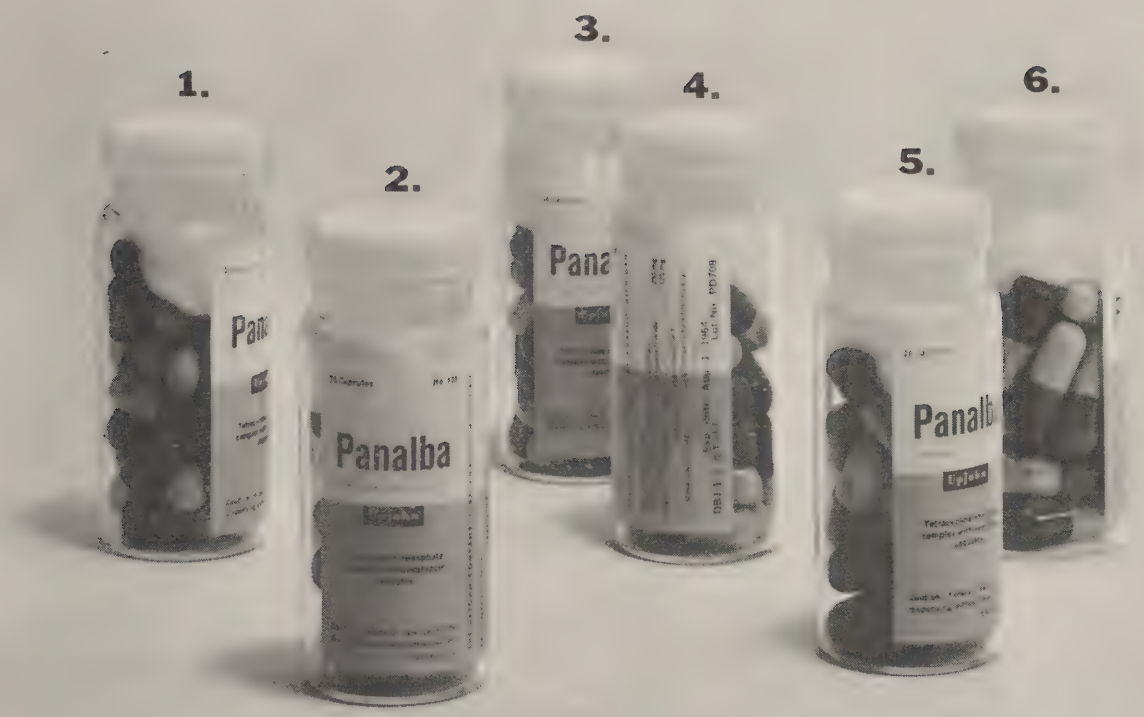
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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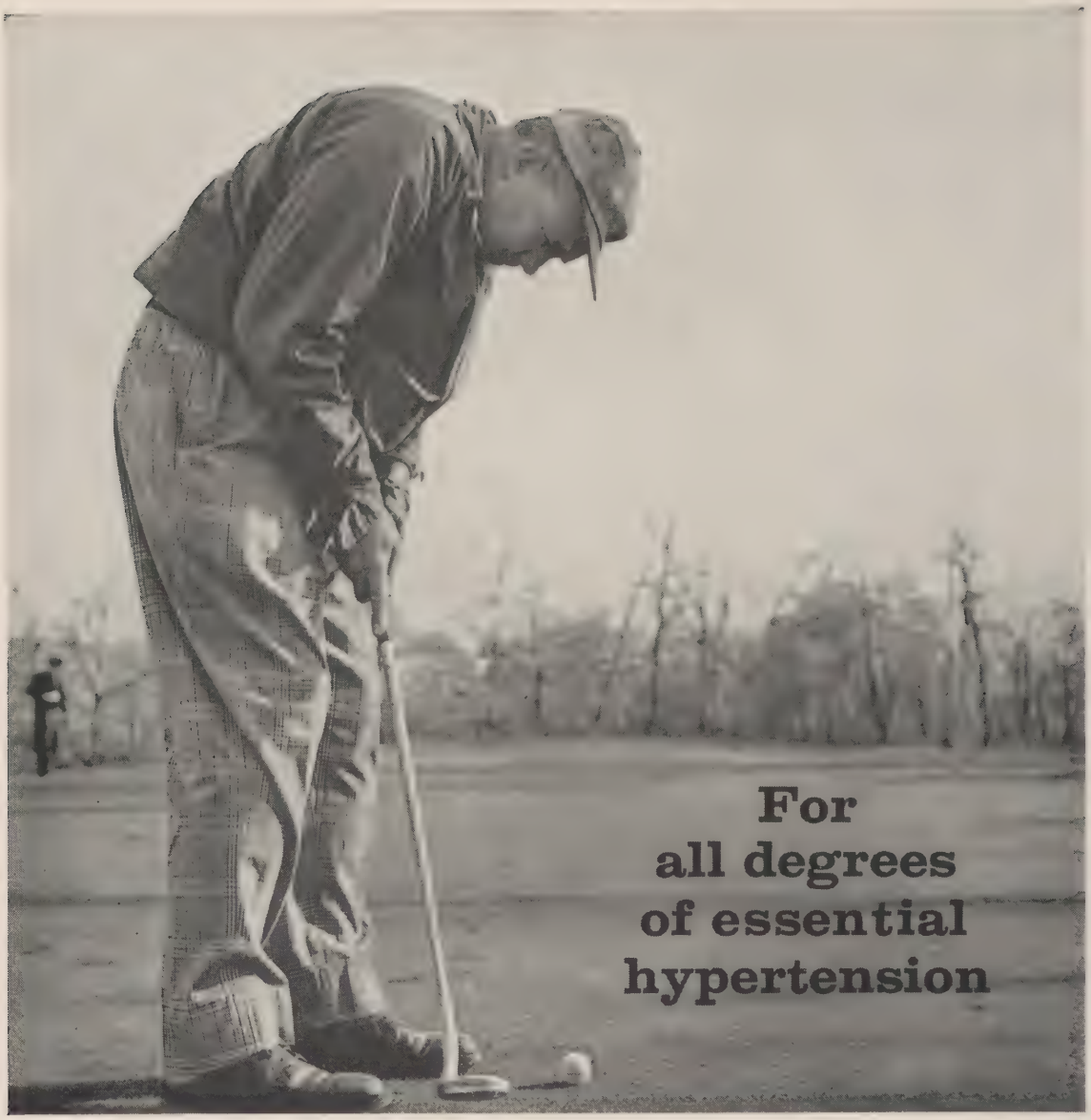
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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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*R. V. Ford: Cur. Ther. Research, 2:51, 1960.

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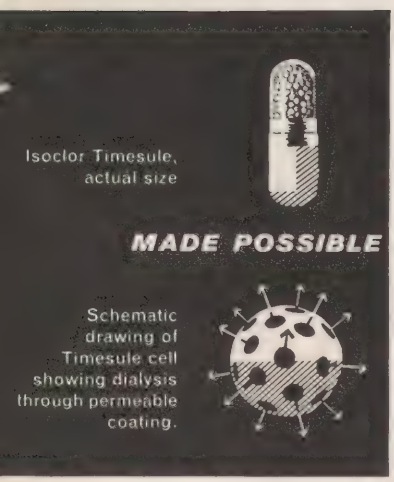
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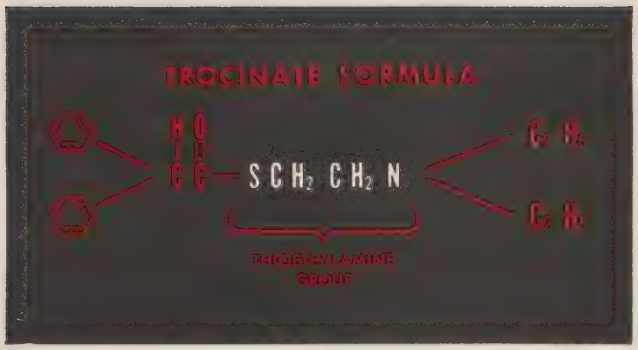
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The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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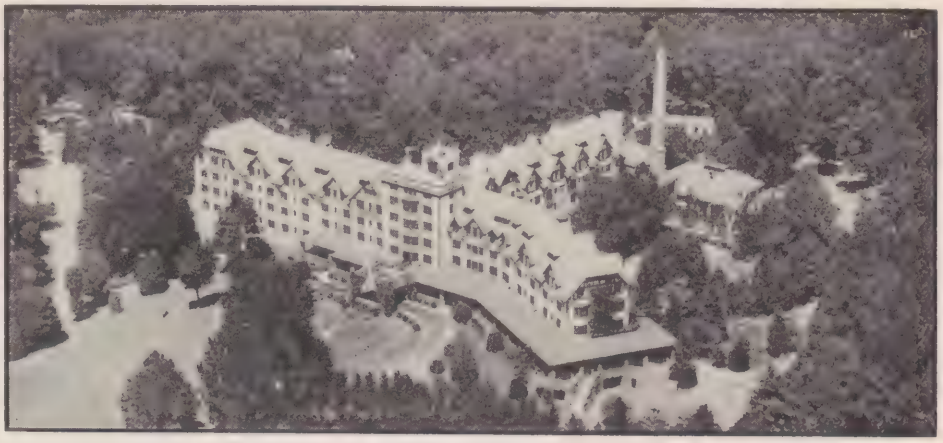
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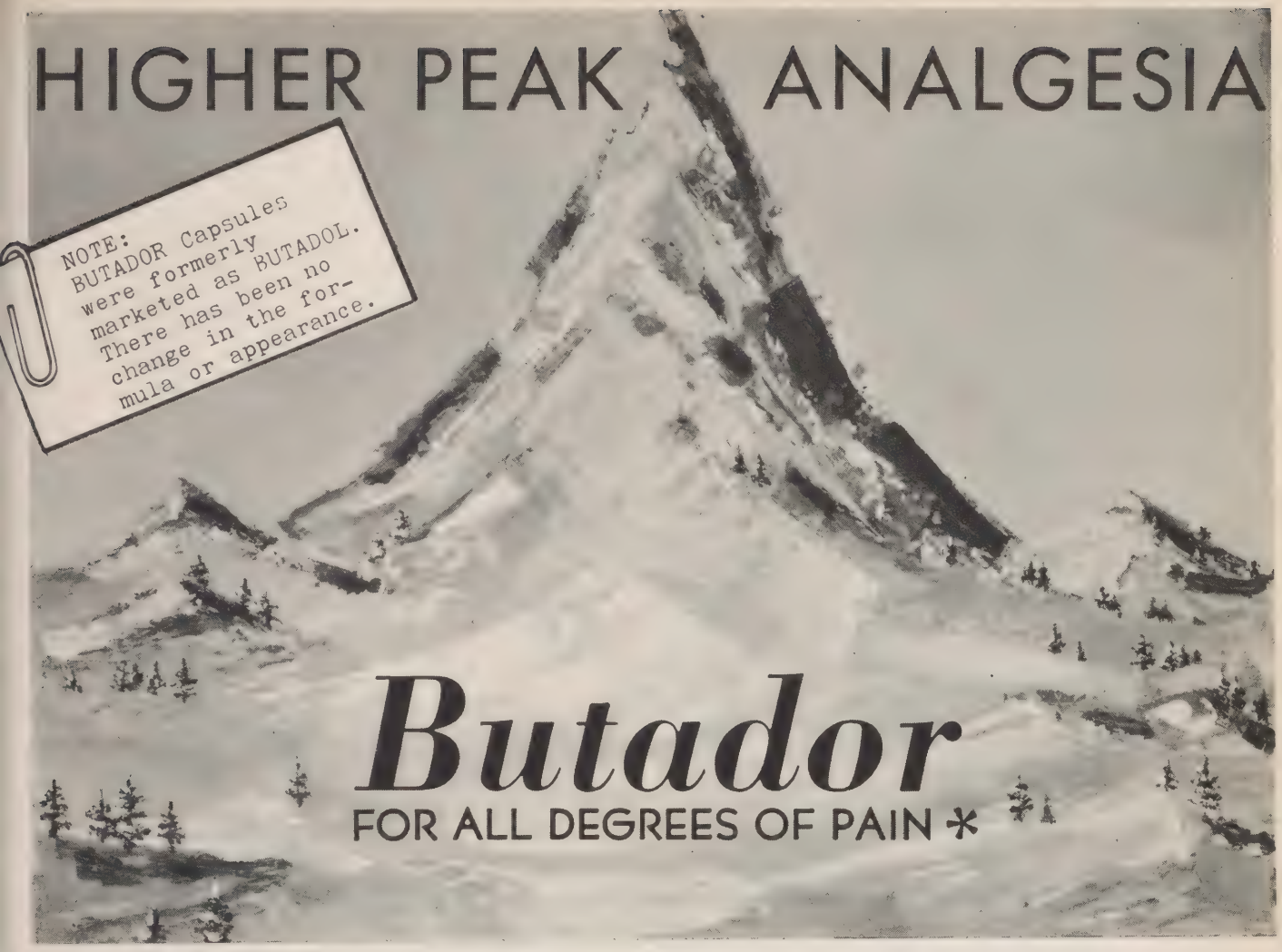
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PAGE 643

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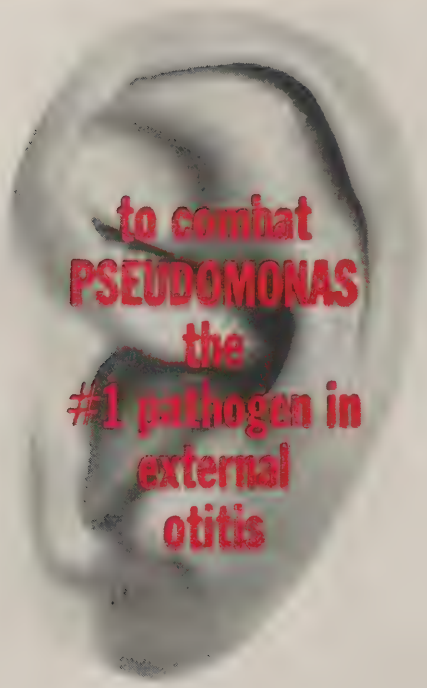
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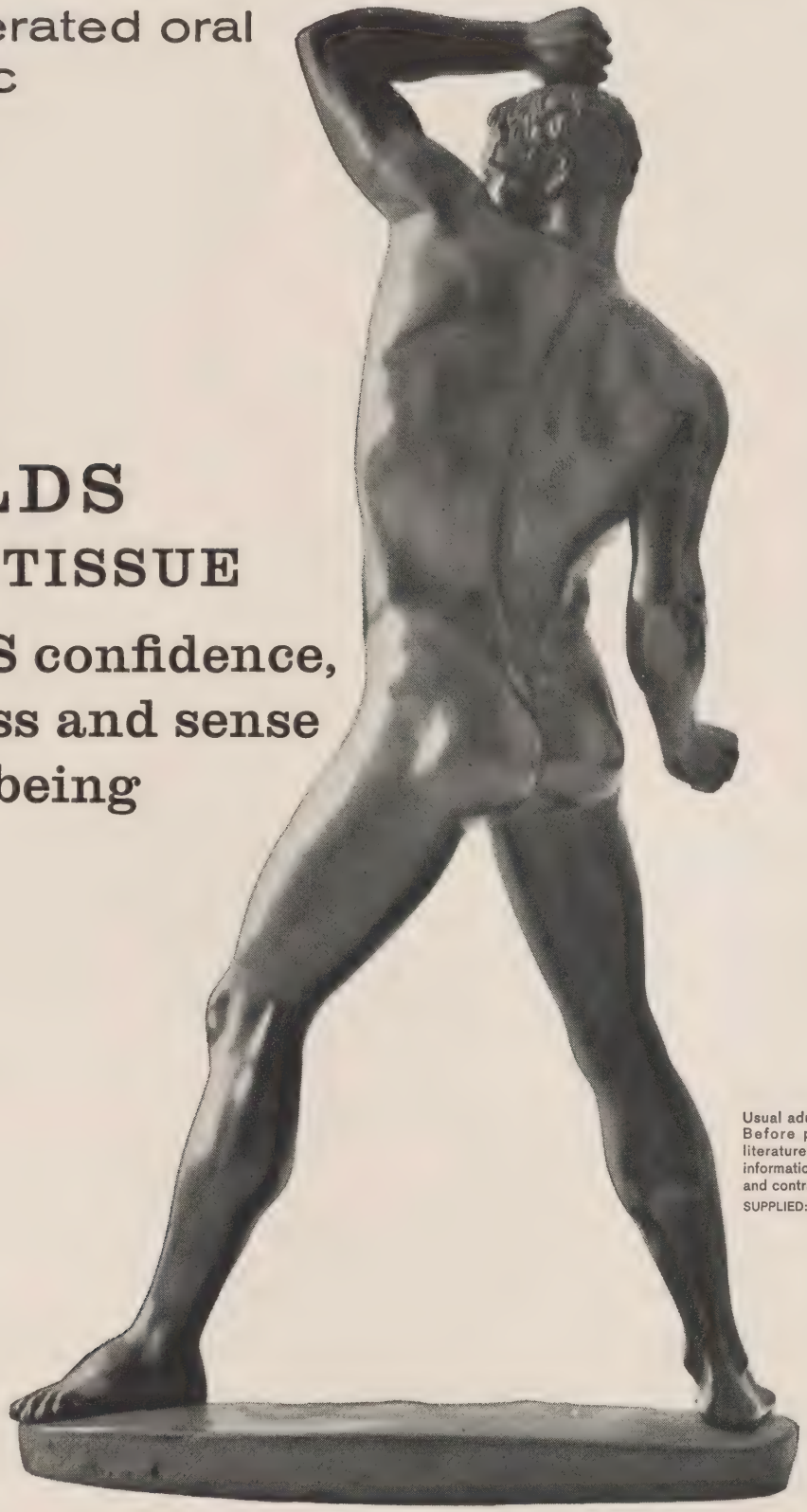
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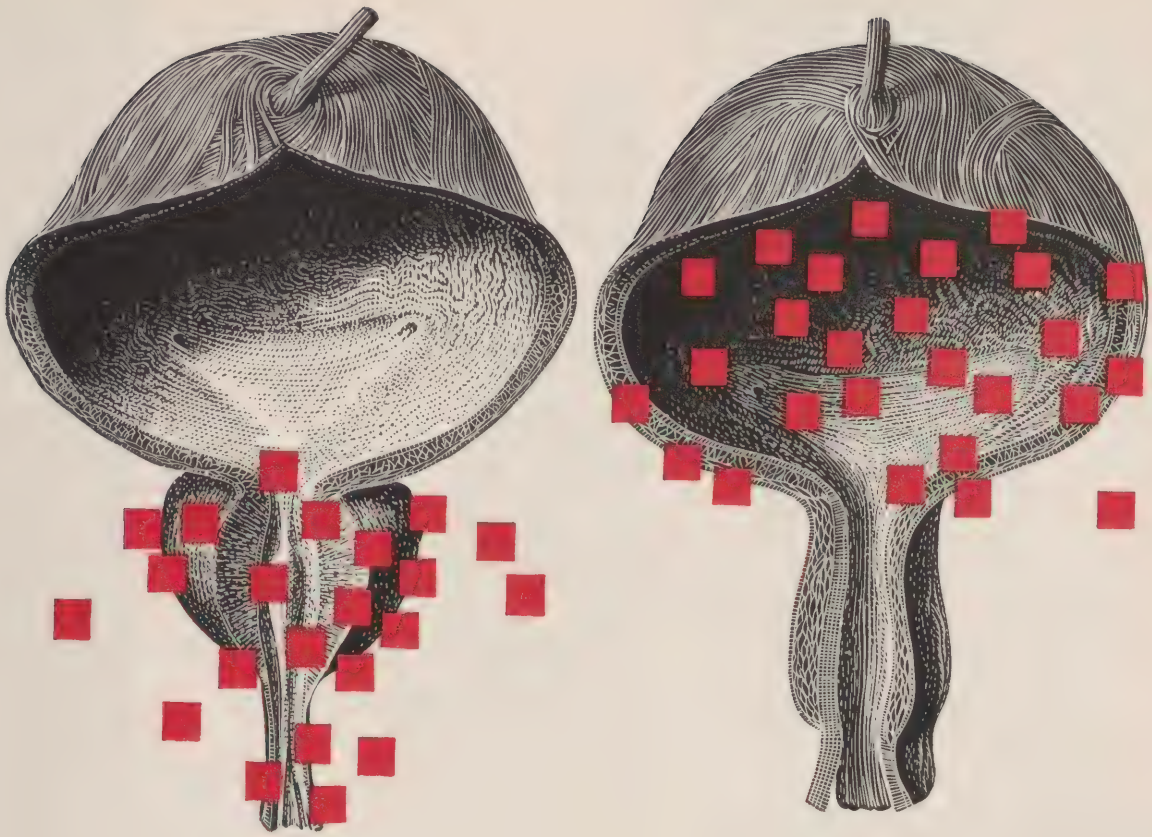
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WHEN DISCOMFORTS MOUNT WITH THE POLLEN COUNT

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antihistaminic-antispasmodic

RELIEVES SYMPTOMS OF HAY FEVER

BENADRYL provides effective dual action to help control the allergic attack.

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93162

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THE SUCCESSOR TO THE TRANQUILIZERS

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The Journal of The SOUTH CAROLINA Medical Association

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Medical College Clinics

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VOLUME 58 SEPTEMBER 1962 NUMBER 9



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for the treatment of psychosomatic, neurotic and psychotic disorders and selected cases of alcoholism and drug addiction.

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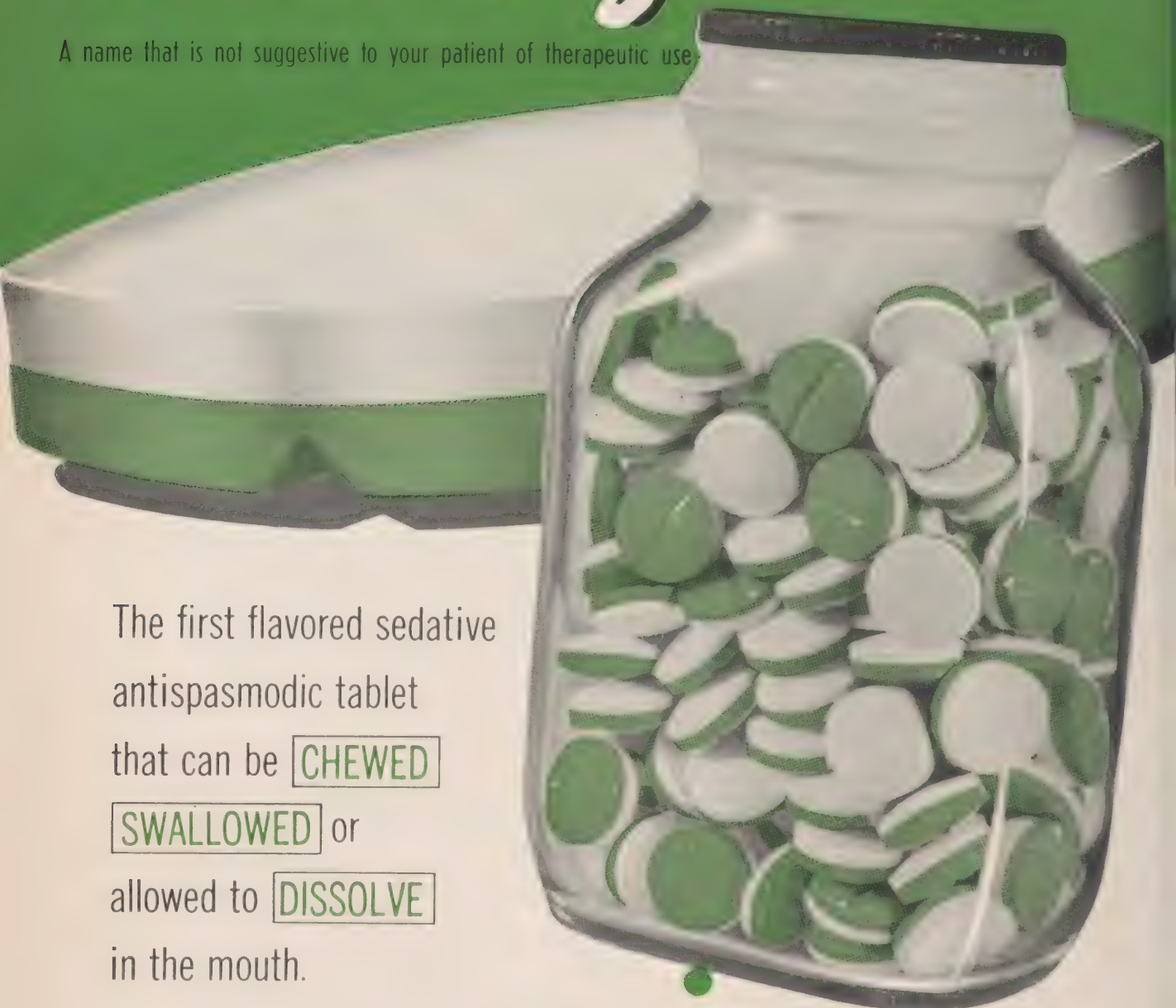
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The Journal of The
SOUTH CAROLINA
Medical Association

SEPTEMBER, 1962 — VOL. 58, NO. 9

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Contributions of Original Articles

Length—Short articles of about 3,000 words (about 10 typewritten pages, double spaced) are preferred. Longer articles ordinarily will defer to the shorter ones in schedule of publication.

Manuscripts—Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.

Illustrations—Ordinarily publication of 4 small illustrations or the equivalent accompanying an article will be paid for by The Journal. Any number beyond this must be paid for by the author except under unusual conditions. Illustrations should be sent as glossy prints or graphs in black ink with lettering large enough to show after reduction.

References—Should conform to the following order: surname and initials of author, title of article in small letters, name of periodical, with volume, page, month, day of the month if weekly, and year—e. g.: Lee, G. S.: The heart rhythm following therapy with digitalis, Arch Int Med 44:554, Dec. 1942. They should be listed in alphabetical order and numbered in sequence. Standard abbreviations for journals should be used. Note that periods are not used with these abbreviations as indicated by the Index Medicus. Other abbreviations should also be standard—e. g. mg., ml., Gm.

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CME-6630

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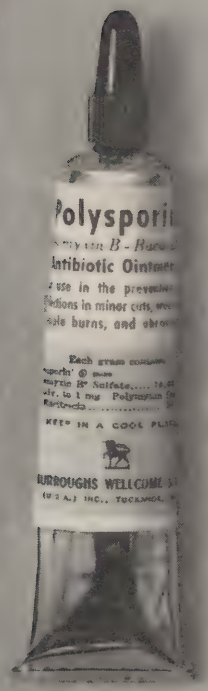


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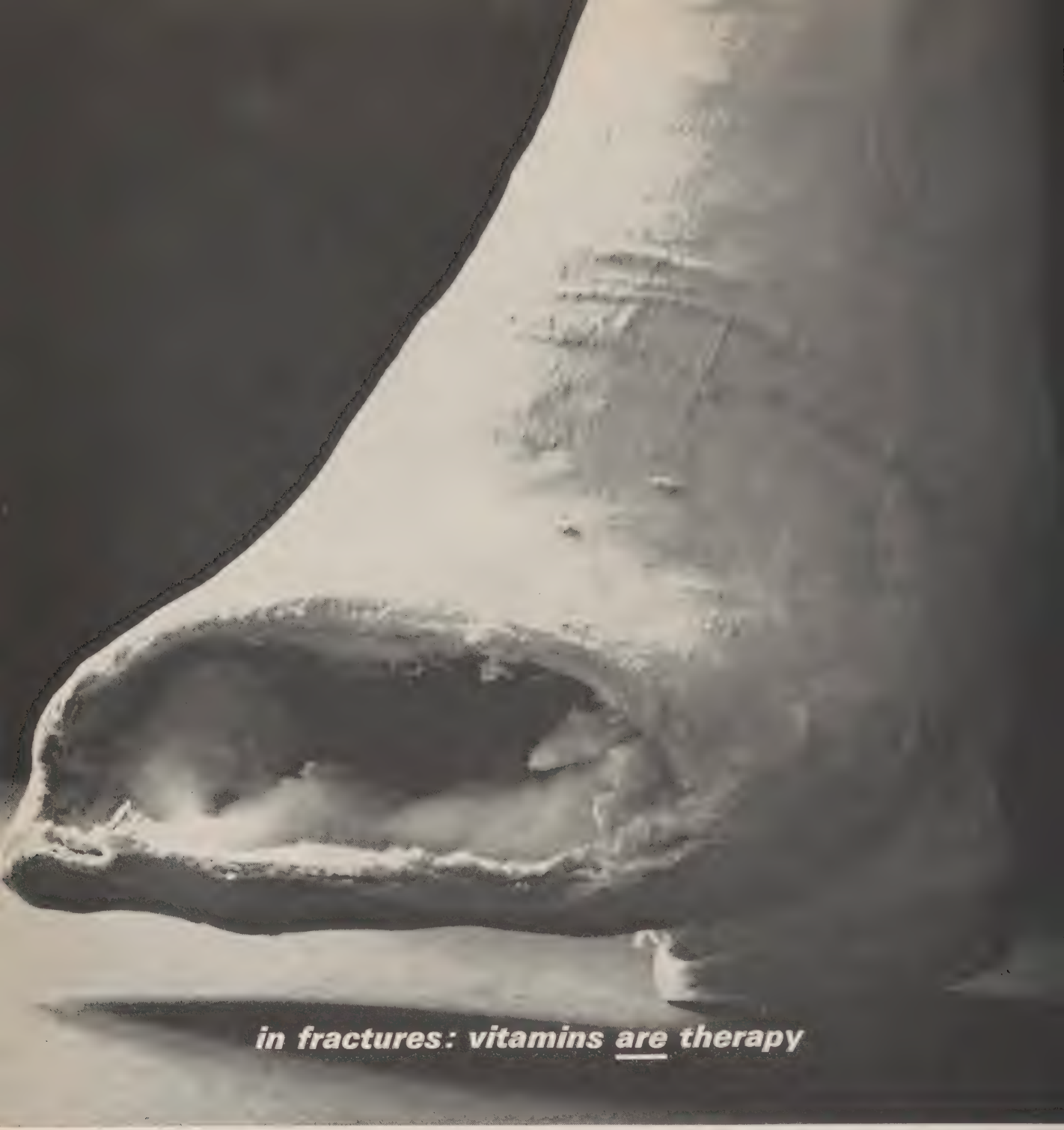
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Important: Before prescribing DBI-TD, the physician should be thoroughly familiar with directions for use, including indications, dosage, possible side effects, precautions and contraindications. Write for complete literature.

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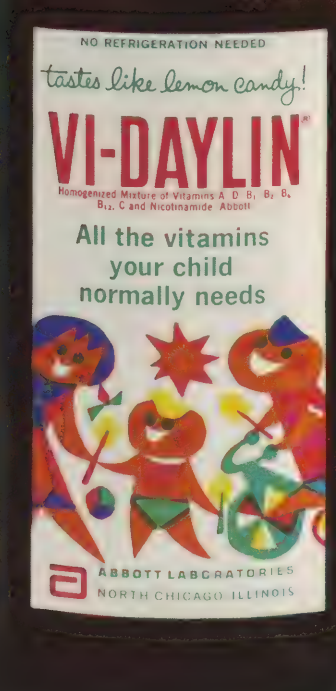
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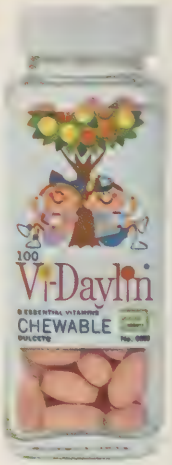
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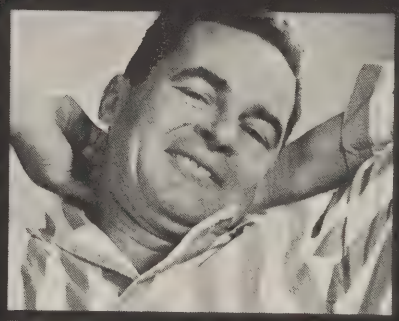
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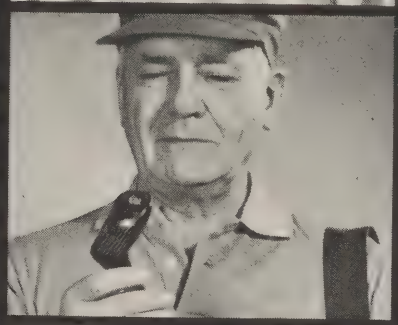
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The Journal
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VOLUME 58 September, 1962 NUMBER 9

SPONTANEOUS RUPTURE OF THE ESOPHAGUS

A CASE REPORT

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GEORGE M. GRIMBALL, M. D.

Greenville General Hospital
Greenville, S. C.

Spontaneous rupture of the esophagus is a condition which has gained most of its recognition in the past 15 years, although it was first reported in 1724. The first reported survival was in 1911. The first reported in the United States was a case treated in 1943 by Overholt in which he used a posterior mediastinotomy and bilateral pleural drainage.[1] In 1947 cases successfully treated by thoracotomy and repair were reported by Barrett in one instance and by Olsen and Clagett in another.[2] The literature now contains reports from over 200 cases. The seriousness of the insult is well illustrated by its very high mortality rate. Clain, and Hefferan reported only 20 to 40 per cent survival rate.[3]

Case Report: The patient, a 44 year old white female, was brought to the Greenville General Hospital emergency room at 2:30 A. M. on October 3, 1961. She was in extreme pain and was unable to give a detailed history at the time. The family stated that just prior to admission she had been vomiting blood and had fallen, injuring her left shoulder. The illness was acute and she had worked the day before admission.

Physical examination at that time revealed a thin, poorly nourished white female who was thrashing about in severe pain. Her blood pressure was 100/80, mm. Hg., pulse 96, and temperature was 98.2° F. rectally. She had some neck vein distention, her lungs were clear to ausculatation and percussion. There was a well healed mid-line suprapubic scar. Peristalsis was hypoactive. Her abdomen was flat and no organs or masses were palpable. The patient had moderately severe tenderness to palpation in the left upper quadrant and epigastrium with muscle guarding in these areas. There was no rebound tenderness. Rectal examination was not remarkable except for the presence of tarry feces.

The past history was interesting in that the patient had radiation therapy for carcinoma of the cervix in 1955. In 1956 she had a radical panhysterectomy for recurrence of the cervical carcinoma. There has been no evidence of recurrence since 1956. She had also been hospitalized in April, 1961 with abdominal pain which was found to be secondary to an acute duodenal ulcer.

X-ray films of the chest and abdomen were obtained at 4:00 A. M. and were negative except for slight suggestion of a small area of free air beneath the left diaphragm. The hemoglobin was 9 Gm. WBC was 20,300 with 73 per cent segmented neutrophils, 12 per cent stabs, and 15 per cent lymphocytes in the differential count. The blood pressure had fallen to 70/44 and the pulse was up to 120 two hours after coming to the emergency room.

The initial impression was that this patient had a bleeding duodenal ulcer and was in shock secondary to blood loss. She was given 500 ml. of whole blood rapidly and showed definite improvement, her blood pressure coming up to 90/70. A second unit of blood was started. A Levine tube was inserted and the patient was sent to the ward at 7:30 A. M. She was also given Demerol (meperidine) 75 mg. at 3:40 A. M., and 50 mg. at 6:30 A. M. because of the severe pain.

She was again examined about 30 minutes after having arrived on the ward, and after having her second unit of blood. At this time the pulse was 140,

the neck distention had progressed and the patient was slightly cyanotic and was also developing abdominal distention. The lungs were re-examined at this time and the breath sounds were noted to be markedly diminished in the left base. Because of these changes the x-ray examination was repeated (3½ hours after the initial films). To our surprise the chest film at this time showed an air fluid level in the left hemithorax on a level with the hilus with clouding of the lower hemithorax. The abdominal films again suggested free air but were not diagnostic (subdiaphragmatic free air has never been reported with this contion).[4] Left thoracentesis was attempted in three locations but only 5 ml. of a brownish fluid was obtained. It was felt the patient most likely had a ruptured esophagus. Her temperature at this time had risen to 105° orally and her pulse had remained at 140. Her blood pressure was 90/70. Esophageal studies with contrast media were not done because of the patient's poor condition and because it was felt the diagnosis had been established. Surgical intervention was delayed until 4:00 P. M. on the day of admission in an attempt to lower the temperature by alcohol sponging.

At surgery the left hemithorax was entered through the 8th intercostal space. There was an estimated 2,000 ml. of thin brownish fluid in the hemithorax and the parietal and viseral pleura were covered with a thick yellow exudate. A vertical vent was noted in the inferior-lateral mediastinal pleura extending from the diaphragm cephalad approximately four cm. This opening was extended superiorally and the esophagus was exposed. The esophagus had a three cm. vertical tear in its lateral aspect. The edges were smooth with no gross evidence of esophagitis or ulceration. A three layer closure of the esophagus was done using a continuous inverting chromic suture on the mucosa and interrupted silk on the muscle layer. A continuous suture was used for hemostatis and to expedite the closure. The lower one-half of the pleural rip was closed with chromic cat-gut. The exudate was wiped off the pleura as completely as practical and the wounds were closed in layers. Two No. 32 mushroom catheters were placed near the perforation, brought out in the midaxillary line and connected to underwater drainage with suction. The patient's condition in surgery was poor; the blood pressure was unobtainable during the mid portion of the procedure. The blood pressure was maintained at 90 systolic during the last portion of the procedure with Levophed (levarteronol) drip. The patient's condition was satisfactory and stable until 20 hours post-operatively at which time she became comatose with a temperature of 104.4° rectally. Her blood pressure was 120/90, pulse 90, and respiration 16, but labored. Her color was good. Our only explanation for this apparently paradoxical situation with slow pulse and respiration in face of high fever was over depression from 2 mg. of Levodromoran (levorphanol) given 2 hours earlier. Nalline hydrochloride (nalorphine) 15 mg. was administered intravenously along with 300 mg. of Solu-cortef (hydrocortisone) and her mental status cleared rapidly. X-ray film of the chest at this time showed a right pleural effusion and 240 ml. of thin blood tinged fluid was removed by thoracentesis.

The remainder of the post-operative course was relatively smooth. The nasogastric tube was left in place 10 days after which a bland diet was given without difficulty. X-ray examination of the upper gastro-intestinal tract showed no esophageal deformity two weeks post-operative and duodenal ulcer was again noted. The patient was discharged on October 29, 1961, 26 days after admission.

She subsequently developed localized empyema in the left apex posteriorly from which alpha streptococcus was cultured. This was treated by closed thoracotomy and suction drainage for five days with complete resolution of the abscess. She is now feeling well except for some mild ulcer symptoms for which she is currently on an ulcer regime.

Discussion

In retrospect this patient presented with a fairly typical picture of a ruptured esophagus. The typical triad of symptoms is (1) rapid respiration (2) abdominal rigidity and (3) subcutaneous emphysema at the base of the neck. Our patient had the first two of these symptoms, but the subcutaneous emphysema never appeared throughout her course. Initially, too much emphasis was placed on the hematemesis and the past ulcer history and the severe pain was not adequately explained. In this case the repeated x-ray films, obtained less than four hours after the initial studies, afforded the most important clues to the diagnosis if, indeed, not the diagnosis itself.

We wish to present this case an an illustration of the importance of repeated studies early in the course of a rapidly changing clinical picture which is unexplained by previous physical or laboratory findings. Spontaneous rupture of the esophagus carries a high mortality rate. This is truly a surgical emergency and the mortality rate is directly related to the interval between rupture and surgical intervention. Derbes and Mitchell[1] reported 25 per cent mortality if surgery is delayed 12 hours, 65 per cent after 24 hours, and 89 per cent after 48 hours with no survival after one week without surgery. The clinical picture is usually very typical and suspicion of the diagnosis will lead to its early establishment.

(*See page 355 for references*)

GUIDES TO THE SAFE USE OF BLOOD TRANSFUSION THERAPY

PART II

INDICATIONS FOR TRANSFUSION AND GUIDES TO ADEQUACY OF TRANSFUSION

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Charleston, South Carolina

Blood transfusions are used in the therapy of shock, hemorrhage, anemia, hypoproteinemia, blood coagulation disorders, antibody deficiencies, thrombocytopenia, and hemolytic diseases. The indications, methods for estimating the quantity of transfusion, needs for certain types of blood preparations, and guides to the adequacy of transfusion are discussed. Preoperative transfusion requirements and blood replacement methods during surgery are described. Special considerations are outlined as a guide to the requirements in pediatric transfusion therapy.

The principle indications for blood transfusion are shock, hemorrhage, anemia, hypoproteinemia, blood coagulation disorders, antibody deficiencies, thrombocytopenia, and hemolytic diseases.

Transfusion in Acute Hemorrhage

The indication for transfusion is obvious if the loss is sufficient to warrant replacement. Estimation of the loss will depend upon blood volume hematological studies, and clinical signs. Davidsohn[7] has devised the following chart as a rough guide to the problem based on a 64 kg. (140 lb.) man with a normal blood volume of 4500 ml:

Blood volume Deficit (%)	Blood Loss Ml.	Clinical Findings	Transfusion
10-15	500-750	Initial faint	Not necessary
15-25	750-1250	Moderate shock	Desirable
25-35	1250-1750	Moderate to severe shock	Necessary
35+	1750+	Profound shock	Urgently & immediately needed.

Many patients may remain normotensive after a blood loss of up to 20% of their blood volume especially if they remain recumbent.[10] Laboratory tests are helpful but not entirely reliable. The hemoglobin and hematocrit may not be altered immediately following hemorrhage or not until the hemodilution phase develops. In the face of an emergency need, blood volume determination by the Evans Blue or radioisotope methods are time consuming and difficult to perform. Results may vary by 500-750 ml. or more. Adequacy of transfusion therapy is best guided by the evaluation of the clinical signs. A rise in pulse and fall in systolic arterial blood pressure do not occur until the blood loss is greater than can be compensated for by vasoconstriction. If the patient is a well-nourished and hydrated adult these changes do not occur until after 750 to 1500 ml. of blood has been lost. The pulse rate usually rises first. If this rise does not maintain the systolic pressure by increasing the cardiac output, then the later sign of hypotension develops. In minor degrees of hemorrhage and especially in operative procedures in which the further loss of blood is expected to be slight the use of a blood substitute such as low mole-

cular weight dextran provides the safest solution. Allen[2] stresses the abuse of blood transfusion practices by the use of the single transfusion. "If one transfusion is sufficient, it is probable that fluid other than blood might serve equally as well and with less risk." When hypotension develops in situations associated with little or no blood loss, causes of vasodilatation should be looked for. Often, little or no sweating occurs in such cases and the pulse rate may not be elevated. This situation most frequently entails in the elderly surgical patient in the face of hypoxia, spinal anesthesia and manipulation of abdominal viscera, and develops from pain in the conscious patient. Such hypotension is best treated by the use of a vasoconstrictor drug and relief of the stressful situation. Vasoconstrictor drugs have no place in hypovolemic hypotension, except possibly the employment of norepinephrine (Levophed) for increasing myocardial tone following massive hemorrhage when used in conjunction with appropriate transfusion. In hypovolemic hypotension the vasoconstrictor mechanism is already ineffective and overcome by the decreased blood volume. Contrasted to hypovolemic hypotension, if blood is given in the face of normovolemic or vasodilatory hypotension, it merely over-extends the blood volume at a time when there is little or no peripheral resistance.

When dealing with hemorrhage, if the blood pressure rises and the pulse slows the response to transfusion can be considered good. If the blood pressure has remained nearly normal and the pulse is weak and thready, consideration should be given to further transfusion. Pallor, coolness, and sweating indicate the degree of adrenergic compensatory vasoconstriction and these may be the first to show improvement after transfusion is started. As the veins begin to fill, there is a good indication that blood volume has returned to normal.

Transfusion for acute hemorrhage should be started as soon as possible to avoid mobilization of body reserves. When reserves are spared, the patient is in a much better position to withstand an operation or second hemorrhage. When the patient is in severe shock, the blood should be given rapidly. It is recommended that 500 ml. in five minutes or 1,000 ml. in 10 minutes be given.[17] If there is no elevation of blood pressure following such administration, the suspicion of uncontrolled bleeding and the need for immediate operation arise. A large needle of at least 15 gauge should be used to prevent undue hemolysis when employing rapid transfusion. As a general rule, 500 ml. of blood should be given to such patients after a normal blood pressure has been obtained. Group O Rh negative blood of a low AB agglutinin titer can usually be obtained with the least delay. The use of dextran in quantities greater than 1,000 ml. may tend to promote bleeding because of interference with the clotting mechanism.[17] If blood from the pleural or abdominal cavity is not evidently contaminated such blood is very suitable for autotransfusion if it is collected in a sterile citrate system.

Transfusion in Shock

The considerations given to transfusion in acute hemorrhage also apply to the therapy of shock. Transfusion is indicated in oligemic shock which is associated with a deficient circulating blood volume. It is to be re-emphasized that in evaluating the replacement of blood in concealed hemorrhage causing shock, that blood volume deficits of 20% or less may not result in hypotension if the patient is lying down. Serious consequences may result from further stress as for instance from a general anesthetic.

In treating burn shock, type-specific blood should be used and not a universal donor blood (Type O) unless the patient is also type O. The agglutinins in such donor blood are prone to hemolyze the patient's damaged red cells. Plasma or plasma substitutes may be employed until type-specific blood is available.

Packed or sedimented red blood cells constitute the best replacement therapy for the patient with myocardial infarction and congestive heart failure, especially if the need for transfusion arises during or shortly after an operation with a concomitant blood loss. Such concentrated red blood cells restore the hema-

tological deficit with less threat of endangering over-expansion of the blood volume.

Transfusion for Bleeding Problems

When coagulation defects exists, proper steps should be taken to provide a diagnosis of specific clotting factor deficiencies. Five of the soluble plasma protein components necessary for clotting can be provided by transfusion and the first four to be mentioned are usually available for the correction of the deficit when a fresh blood preparation is used.

1) *Prothrombin*: Whole blood, fresh and stored plasma are temporarily effective in restoring prothrombin deficiency. 200-500 ml. of each is usually adequate. This may need to be repeated every 24 hours until the basic cause has been eliminated.

2) *Prothrombin activator*: This consists of a labile and stable component. The labile catalyst is present in fresh plasma, while the stable factor is available from fresh or stored plasma.

3) *Thromboplastinogen*: This is an important factor involved in hemophilia. In treating hemophilia 1,000 ml. of fresh (less than 24 hours old) whole blood is needed or 500 ml. of fresh plasma or its dried or frozen equivalent prepared from fresh plasma, or a corresponding amount of anti-hemophilic globulin. Further therapy is best guided by the prothrombin consumption test which measures thromboplastic activity.

4) *Fibrinogen.* Usually 0.5 Gm. of fibrinogen is present in 500 ml. of whole blood or plasma. In treating hypofibrinogenemia, fibrinogen previously dried and immediately reconstituted before use should be used. Usually 2 to 3 Gm. are administered and the effects observed. If defective clotting or oozing persists, the dose may be repeated in 30 minutes. Fibrinogen may cause a dangerous intravascular thrombosis and its use must be guarded.[9]

5) *Thromboplastin accelerator*: This is present in platelets and tissue cells and must be released from them. Inadequate or deficient platelets are the source of its deficiency. Direct platelet transfusions are not generally available. Platelet-rich polycythemic blood may at times be useful. As a practical approach to the need for platelet transfusion, carefully collected whole blood obtained by the gravity flow rather than vacuum method, preserved in siliconized or plastic containers, and freshly administered is perhaps the best material.[6]

Chronic and Hemolytic anemia. Packed or sedimented red cells are the best treatment agent. The optimum hematological level for these patients is usually well below normal and they cannot usually maintain normal levels. Attempts to transfuse such patients to normal levels may result in hemosiderosis. Following whole blood and packed cell transfusions such patients may show hemolysis of the transfused cells or increased hemolysis of their own cells. Febrile reactions are common following transfusions in these conditions. ACTH and cortisone may be helpful just prior to splenectomy when large amounts of blood are necessary to prepare the patient for surgery. Steroids may mask the early signs of a dangerous transfusion reaction and consideration should be given to this possibility. Excessive pre-splenectomy transfusion may cause further enlargement of the spleen and add to the difficulties at operation.

Preoperative Transfusion Needs

Replacement therapy in the preoperatively depleted patient involves restoration of the blood volume, red cell mass, and proteins to normal levels. Blood transfusion may play an important part in all of these. Complications, sometimes fatal, often arise during and after surgery in the depleted patient. The normal blood volume is estimated to be 7 to 8 per cent and the red cell mass 3 to 4 per cent of the body weight.[14] Certain influences may alter the volume-weight relationships. In the obese patient the weight in excess of the ideal weight is associated with an increase in blood volume of one-fourth to one-third of that expected on a weight basis. Older individuals (over 50 years) normally have about 10% less blood volume than younger adults. The blood volume of women (34 ml./lb.) is lower than that of men (40 ml./lb.) and the red cell mass of women (15 ml./lb.) is likewise lower than for men (17 ml./lb.). Children have the larg-

est relative blood volumes (50 ml./lb.). Gradual weight loss over a 2 to 12 month period is accompanied by contraction of the blood volume, whereas weight loss in a short period of time is not. In planning the replacement therapy, it is extremely helpful to measure the blood volume. Blood volume estimations, when available, are important because as Coller[5] has demonstrated, normal or nearly normal hemoglobin and hemotocrit values may be found in cases of carcinoma, polyposis, diverticulitis of the colon, and other chronic debilitating disorders in which the blood volume is as much as 35% below normal. This is especially true for patients of the old age group who have been on a restricted diet. Perry *et al* also stress this consideration.[14]

When direct blood volume measurements are not available, the adequacy of transfusion replacement may be indirectly measured by the response shown to each transfusion. The vascular compartment resists over-expansion and usually contracts in adjustment to the diminished blood volume. When blood transfusion has restored the blood volume to normal, additional transfusion will increase the red cell mass while the extra plasma will be dispersed from the vascular compartment fairly rapidly. Thus each transfusion given to a patient with a decreased blood volume produces a small increase in the hematocrit until the blood volume is restored. When the blood volume has been restored, a single additional transfusion will produce a marked increase in the hematocrit to indicate that replacement is complete. The usual response in a depleted patient 24 hours following a 500 ml. blood transfusion is an increase in hematocrit of 0.5 to 2 units. When the blood cell volume is restored to normal by the particular transfusion, the hematocrit will increase by 3 to 6 units. When this method is used as a guide in replacement therapy, the state of hydration must be normal.

Blood transfusion is no substitute for proper oral intake in the restoration of depleted protein levels. Each pint of blood contains approximately 35 Gm. of protein. Each pound of body weight lost represents about 15 Gm. of nitrogen or 90 Gm. of protein. Calculation of protein deficit and replacement employing blood on this basis immediately indicates the need for factors other than blood in the replacement therapy. Allen[21] has found the administration of 1,000 ml. of plasma per day and 500 ml. of blood on alternate days a helpful approach. He points out that amino acid hydrolysates are helpful for maintainance, but are of little value in the restoration of a negative nitrogen balance.

Considerations in Pediatric Transfusion Therapy

The surgeon is frequently confronted with preoperative anemic problems in children. Rutzky[16] has evaluated these problems at the Childrens' Hospital of Michigan and the following outline is chiefly based on his recommendations. The transfusion of 10 ml. of blood per pound to a child is roughly comparable to giving three pints to an adult. Whereas many children will withstand such an increase in blood volume, some develop a tachycardia, gallop rhythm, and hepatomegaly. Often those in greatest need of the blood are the least tolerant of such a quantity. Children with severe anemia in association with heart failure, high fever, and infection are notable examples. When the need for transfusion is properly evaluated in terms of the risk, there are few pediatric patients to whom 10 ml./lb. can be safely administered. Rutsky strongly recommends the figure of 5 ml./lb. as a maximal pediatric transfusion, except of course, in replacement following hemorrhage. Such blood should usually be given at a rate of 15 to 20 drops per minute. If the patient's general condition or circulatory status is compromised, only 3 ml./lb. should be employed, and this should be given more slowly. The practice of "push" transfusion is too often a matter of expediency for the physician and, with the dubious exception in the newborn, is seldom justified.

In treating chronic anemias it should be realized that the greater the severity of anemia, the greater is the likelihood of precipating cardiac decompensation by further increase in blood volume. Less volume should be ad-

ministered at any one time to the patient with severe chronic anemia than to the patient with moderate anemia. Fatalities have occurred from "rush" replacement. Generally a child with a chronic anemia that has developed slowly is remarkably lacking in symptoms until the hemoglobin level falls to about 5 Gm./100 ml. In contradistinction to this, children with chronic anemias with 3 Gm. hemoglobin or less are often clinically decompensated or become so on slight provocation. When such pediatric subjects are to be transfused, they should be properly sedated, oxygenated, and comfortably arranged with the head of their bed elevated. It has been found that even a transfusion of 5 ml./lb. will occasionally result in decompensation in such severly anemic patients. Because of this, Rutzky has suggested the "3-4-5" rule. Thus the prescribed volume of transfusion is gauged according to the hemoglobin concentration:

Patient's Hemoglobin	Volume of Transfusion
3 Gm./100 ml. or less	3 ml. per pound
4 Gm./100 ml.	4 ml. per pound
5 Gm./100 ml.	5 ml. per pound

Should circulatory status appear to be compromised in the face of such transfusion, the drip rate should first be slowed. If this is ineffective, less blood should be given. Usually 1 to 1.5 Gm./100 ml. rise in hemoglobin may be expected after such transfusions. In the treatment of severe chronic anemias packed or sedimented red blood cells should be used when available. The same transfusion volume rules apply. If the chronically severe anemic patient is in a state of cardiac decompensation when first seen an exsanguination transfusion should be used. This is performed by removing 3 to 5 ml. of blood per pound and giving 3 to 5 ml. of packed or sedimented red blood cells per pound.

In acute anemias the problem is somewhat different. Low hemoglobin levels are not tolerated as in chronic anemias and must be more rapidly improved. In acute hemorrhage which is severe and not immediately controllable, volume for volume replacement is necessary. The principles for replacement in acute hemorrhage and the guides during such replacement are the same as for adults which have been previously mentioned.

Operative and Postoperative Transfusion Needs

Since transfusion therapy at the time of surgery is of substantial importance, a brief consideration of certain principles of this matter will be dealt with. More extensive and excellent considerations are provided in the literature.[1, 3, 4, 8, 10, 12, 13, 15] In order to gauge proper transfusion replacement therapy during surgery, ideally a method should be available to measure accurately the loss as it occurs. Generally no such method is available and careful attention must be given to the venous pressure, pulse, blood pressure, sponge analysis and weight, patient's weight, and blood volume measurement. The colorimetric acid-hematin method of Gatch and Little which measures the hemoglobin washed from the sponges, instruments, and linens, is associated with at least 5% error. Losses are not known until the conclusion of surgery. The procedure is difficult to perform. Coller[5] *et al* emphasize the lack of correlation between changes in hemoglobin, hematocrit, and plasma protein concentrations before and after surgery as related to the amount of blood lost. The gravimetric method of Wangensteen in which one ml. of blood loss is reckoned for each gram increase in weight of the sponges and linens is rendered inaccurate by absorbed fat, the intermittent use of wet sponges, personnel deficiencies, and evaporation. Paquin[13] has demonstrated the help of total body weight measurement as a guide to transfusion therapy in cases requiring extensive blood replacement. LeVeen[12] has reported on the use of a conductance measurement device which is calibrated to indicate the amount of blood loss on the basis of electrolyte extraction. This method has not gained general usage, however, further developments of such an approach would be of considerable interest.

Williams and Fine[18] have reported on the use of a rapid method for the measurement of blood volume that may become valuable as a guide to the estimation of blood loss and re-

placement during major surgical procedures. Since the more elaborate methods for determining blood loss at surgery are not generally available, the simpler guides must be employed. Allen and Stemmer[11] indicate that the sponge and lap pad counts may be used as an index of blood loss by assigning 10 ml. loss for each 4 x 8 inch cotton sponge and 100 ml. loss to each 6 x 18 inch cotton lap pad. The degree of soaking of each sponge or pad must be carefully estimated.

In the immediate postoperative or bleeding patient in whom large transfusion volumes have been employed, blood volume determinations are of considerable value. Hemoglobin, red cell counts, and hematocrit determinations are of very little value until several hours are allowed for homeostatic adjustment. Perry *et al*[14] emphasized two possibilities for confusion in the immediate postoperative period. First, it is not uncommon to notice a transient asymptomatic hypotension in the immediate postanesthetic period which is not the result of blood loss. Sometimes this hypotension lasts several hours. There may be no associated change in pulse, skin turgor, or temperature. Although the causes are not fully understood, changes in pH and carbon dioxide tension secondary to anesthesia and especially following cyclopropane have been implicated. Other possibly related factors are pain, hypoxia, and the influence of drugs (tranquilizers). Second, the development and influences of the "operative third space" may cause confusion. There is a normal postoperative expansion of the plasma and extracellular fluid volume and secondary to this a slow drop in the hematocrit. Hemodilution which follows is a result of retention of exogenously administered fluids and a shift of water from the intracellular to the extracellular compartment. This change is usually apparent by 24 hours postoperatively and is maximal at 3 to 5 days. When resolved, the hematocrit returns to its normal level. Consideration of these two events, when properly evaluated, avoids over-transfusion. It is to be emphasized however, that under-transfusion is more often the practice. Such a practice is the result of unsystematic estimation and inadequate clinical judgment. All available aids must be employed for the safe use of blood transfusion therapy in these situations.

Summary

1. The principal indications for blood transfusion and guides to proper quantitation are discussed.

2. In acute hemorrhage transfusion is indicated if the loss exceeds 15% of the patient's blood volume. Hemoglobin and hematocrit levels may not be immediately altered. Transfusion volume may be guided by clinical signs. Diminishing pallor, coolness, sweating, and pulse rate and rising blood pressure indicate a proper response to transfusion. Vasodilatory hypotension must be differentiated from hypovolemia. A plasma substitute provides safer therapy when a single transfusion is required. At least a 15 gauge conduit should be employed for a rapid transfusion.

3. Oligemic shock with a deficient circulating blood volume requires transfusion. Recumbency may mask a 20% blood volume deficit. Further stress may lead to serious consequences. Packed red cells are often required for the patient with a defective heart. Type-specific blood should be used for treating burn shock.

4. In coagulation defects diagnosis should be directed to the specific clotting factor deficiency. Prothrombin, prothrombin activator, thromboplastinogen, fibrinogen, and thromboplastin accelerator deficiencies may be benefited by blood transfusion.

5. Packed or sedimented red cells are the best treatment agent when transfusion is needed in chronic or hemolytic anemias. Optimum hematological levels are usually subnormal in these anemias.

6. The use of transfusion therapy in preoperative restoration of blood volume, red cell mass, and protein levels is described.

7. For elective transfusions in pediatric patients 5 ml./lb. is a safer maximal amount than 10 ml./lb. "Push" transfusions are seldom justified. The "3-4-5" rule of Rutzky is advisable for transfusion therapy in chronic anemias in children. That is, 3 ml./lb. at a hemoglobin

level of 3 Gm., 4 ml./lb. at a level of 4 Gm., 5 ml./lb. at 5 Gm.

8. Guides for estimating and replacing operative blood loss are discussed.

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Cyanosis In Premature and Newborn Infants

The Subcommittee on Accidental Poisoning of the American Academy of Pediatrics is alerting Fellows of the Academy to the possibility of a new chemical cause of unexplained cyanosis in infants due to methemoglobinemia.

As a result of investigations by Benjamin A. Kagan, M. D., it is believed likely that autoclaving diapers that have been rinsed with a bacteriostatic chemical called "TCC" (3-4-4' trichlorocarbanilide) can cause degradation of this chemical to chloranilines which in turn, through skin absorption may produce sufficient methemoglobinemia to result in clinical cyanosis and anemia. Thus far there have been about 18 cases detected from three hospitals throughout the United States. Although there have been no fatalities and it cannot be stated with absolute certainty that "TCC" is the only causative agent, because of the probability involved, the manufacturer has advised the formulators of products incorporating "TCC" in their rinses to withdraw them from the market.

If unexplained cyanosis occurs in infants whose diapers have been autoclaved (boiling is *insufficient* to cause degradation to chloranilines), the Subcommittee suggests checking to see if "TCC" or any formulations containing it, have recently been added to any of the soap, detergent, or sanitizing chemicals used in the laundering process.

MEDICAL SCHOOLING IN SOUTH CAROLINA

KENNETH M. LYNCH, M. D., D.Sc., LL.D.

In any story of medical education, particularly in relation to South Carolina or the Medical College of South Carolina, such as I have been urged to undertake,* there would of course be reference to the periodic promotion of the idea of securing the establishment of one or more additional similar institutions. Ordinarily such reference would not be done out of chronological order. However, since the idea has achieved somewhat wide promulgation at the present time, the "cart is put before the horse" here. Anyhow, a story told backward may sometimes be best.

One of the reasons why the present writer is reluctant to enter into discussion of any subject that may be problematical for the State is the fine personal treatment and wholehearted support he was accorded by all branches of government, legislative, judicial and executive, during the period when he was head of the Medical College.

There is really nothing new about the proposal to establish another medical school in South Carolina, although, in each instance of active promotion, apparently the proposers had not studied the history of such movements, or of medical education in general. Elsewhere in my projected story on the medical school, as tentatively planned, an old saying that "he who will not take the lessons of history is destined to repeat the mistakes of his predecessors" may be used again, but here is a particular case in point. There are many lessons in the history of medical education which should be judiciously studied and weighed before any fixed position may be taken competently on the establishment of a medical school.

In the early eighteen hundreds, the president of the South Carolina College (now the University of South Carolina), Dr. Thomas Cooper, was one of the persons urging the establishment of a medical school in the State. It is recorded that he came into agreement with the Medical Society of Charleston that the best location for such an establishment was Charleston, rather than Columbia.

Now it would not be realistic to suppose that President Cooper was the only conferee on this question, and it goes without saying that others were concerned, particularly the doctors of Columbia. In most instances, then and previously, as well as for almost a century thereafter, medical schools were established by practicing physicians—or at least by their instigation. Hence it seems a reasonable question as to whether President Cooper and some of his unidentified confreres gave up easily and joined wholeheartedly with the Charleston doctors.

The Medical College of South Carolina was chartered by the General Assembly in 1823, as a "proprietary" (privately owned) school, but not on the first petition by the Medical Society of South Carolina (Charleston). The first request included an *appropriation;* the subsequent successful petition *did not.*

Within a few years, by reason of schism in the ranks of the physician "proprietors," a second medical school, The Medical College of the State of South Carolina, was chartered, also by the same Charleston doctors who had composed the original faculty. A new faculty elected by the Medical Society assumed charge of the old building on Queen Street, while the first faculty became now the faculty of the newly organized and competitive school, conducting its activities in a theater building on Broad and New Streets. The first school continued to operate until 1838, when the Medical Society discontinued its sponsorship. The faculty of the first school then assumed the entire responsibility for the operation and moved back into the Queen Street building. However, from then on it operated under the charter of 1832.

*Dr. Lynch has been requested by the Board of Trustees to write a history of the Medical College.—*Ed.*

It is a curious thing that, although the original school was kept in operation in the interim, the surviving school did not revert to the original name; that was accomplished by legislative Act in 1952, a hundred and twenty years later.

Although it may be assumed that the idea of establishing another medical school in Columbia did not die out, it apparently did not become an issue again until 1866, probably incited by the fact that the school in Charleston was closed for four years during the Civil War, 1861-65.

Hollis* states that the Governor (Perry) arguing for transforming the South Carolina College into the University of South Carolina in 1865, "desired to add chairs of law, medicine and modern languages." The following excerpts from Hollis' two volume work give the story of the venture of the University of South Carolina in operating a medical school during that period.

"Late in 1866 the 'faculty chairman (Barnwell) urged the trustees . . . to take steps to create schools of law and medicine,' and 'in 1866 an Act was passed (by the General Assembly) establishing a school of law with one professor and a school of medicine with two.' This act also 'granted authority . . . to confer . . . the degree of doctor of medicine, the recipients of which were admitted to practice in South Carolina.'" No money was appropriated for the school, but the trustees were instructed to establish it "as soon as possible."

In June 1867 the two professorships for the medical school had been filled, and it was reported in November of that year that the new school had been "fully organized." It opened in October 1867 and graduated four doctors of medicine, fully licensed to practice, at the end of the 1868 academic year. Thereafter, from one to seven were graduated annually until 1873.

In the wholesale resignations and firings of the faculty of the College in the extremist period of Negro-carpetbagger assumption of control, the school of medicine faded from the picture, and "ceased functioning altogether in 1876." Meanwhile the Charleston school had resumed its pre-war activity.

In 1883 President McBryde of the University urged that the school be re-established, but "inadequate finances prevented the 'school of medicine and pharmacy' from materializing beyond a two-year preparatory course."

The historian makes no further reference to a medical school at the University of South Carolina, although it is an interesting item that the *American Medical Directory* still lists such a school, but in the small type that is used to designate medical schools which no longer exist.

The next serious conflict on the subject came when the Medical College in Charleston was threatened with extinction by the general revolution in medical education, around the turn of the century.

The issue came in 1913, when by legislative Act the General Assembly accepted ownership and operational support and control of the Medical College as the medical unit of the "state university system." That crisis was not the least in the struggles of the College during the one hundred and forty years since it was founded.

The next episode of open competition for location of the school came in 1944-47, when the Medical College launched its far-reaching effort for modernization, reorganization and expansion into the form of the medical educational, research, service and training complex, for which it was one of the first medical schools to use the term "Medical Center." That program is still in process.*

This progressive move was expected to trigger the traditional battle—and it did. Since large sums of money were called for, the known fact that the State actually had put very little investment in the Charleston plant

*History of the University of South Carolina, U. of S. C. Press, 1951.

*As this article was being submitted for publication the "Summer 1962" issue of the *Medical College of South Carolina Bulletin* was received. It announces the "Service for Tomorrow Development Plan of the Medical College of South Carolina." The present writer is in full agreement with the "Plan" as presented.

opened the door to any seeker of its relocation. In all probability the State could have pulled out of its investment there at a profit, since most of what it owned was contributed by the City of Charleston and its citizens, and by other private donations.

While the proposal at that time that the school be moved to Columbia was not publicized heavily, it was the subject of considerable pressure in political areas, and the Board of Trustees of the Medical College took it under consideration. The Board's decision is recorded in an action stating that the school should remain in Charleston after certain medical educational authorities of national stature and position in the judging of medical schools for 'accreditation' had participated in a more than usual way in support of the plans and the proposed program of the Medical College. It is an open secret that the present writer offered his cooperation in a "go to Columbia movement" if the State would put up the money for construction, development and operation of a full grown Medical Center "from scratch." That would have been much easier, although longer in doing and far more costly. It is no secret at all that the final action on the question—the ratification of the Act appropriating the money for activation of the program of the Medical College — was not taken until almost the last moment allowable in legislative procedure, months after the General Assembly had passed it and adjourned. From that point the issue was to all intent settled permanently.

Actually there is no apparent idea of a change of location in any direct or overt proposal on the present issue. However, the circumstances which would govern the development of a second State-owned and operated medical school in South Carolina are so apparent that to informed and experienced people, that does become the real question. It cannot be realistically conceived that South Carolina will operate two first class medical schools; it is not now providing adequately for the one it has.

While relatively speaking, the State has responded handsomely from 1944 to the near present in making possible the facilities and budgetary essentials of a modern medical educational complex, the conditions of the immediate moment and of the future have suffered such changes that the costs of the approaching period of ten to twenty years may be almost as much more than those of 1960 were over 1944. It is obvious that 37 cents will not buy what a dollar did 20 years ago; it is apparent that the improvements in medicine, and in health and medical education, cost much more now and will in the future than the conditions of the mid-forties required, even if the dollar had not shriveled. As an indicator, the Congressional appropriations for annual support of medical research and scientific training have grown from practically nil to near one billion dollars during the period.

The history of medical education shows that a separation of the four years of undergraduate medical education by the establishment of a "two year" (basic science) school is unsound. One has only to ask the heads of the institutions who have experienced it for emphatic support of that judgment—if that should be wanted. In fact, practically all of the former two-year schools who could find the means have expanded into the full four-year course. There were listed in 1961 (*J.A.M.A.*, Nov. 11, 1961) only two state-operated basic science (two-year) schools, and one of private sponsorship. It is believed that these would also convert to full four-year operation if given the opportunity.

Furthermore, the establishment of any new medical school will be found to have that intention behind it, of offering a four-year course, whether announced, or even admitted, or not. Practically no new school can prepare for all four years at the outset; usually it will be necessary to accomplish a year at a time, taking four years to reach full growth.

The modern medical course is a co-ordinated one; no longer is even a block system of departmental or course teaching considered good. There can be no separation of the basic sciences, the so-called laboratory courses, from the clinical or hospital courses. This

means that any two-year school must provide acceptable clinical instruction required for a co-ordinated course in at least the first two years, and fitted to the recognized curriculum of the third and fourth years. That is not really practical except in a full-grown school; anything less will carry not only the problems inherent in any incomplete enterprise, it will carry the risk of being unable to readily qualify for "approval" as time goes on. Still further, any idea that the cost of a school giving only the first two years of a medical curriculum need be only half that of a four-year school is false. It will prove substantially more than in the comparable two years of the latter if the grade of curriculum and operation is the same. Duplication of each department would be necessary, including two qualified professional heads (very scarce commodities) as well as somewhat more of the other departmental faculty ranks and other technical and service personnel. It would also necessitate duplication of administrative staffs, library, research facilities, etc., and would require relatively more space for the variety of quarters and functions than would be necessary for enlargement of one institution to accomplish the same purpose. It is obvious that the construction and operational costs, both, would be greatly more in two schools than they would be in one, to satisfy the needs of South Carolina. More will be said later about the medical needs of the State and the size of medical classes.

There are many questions and problems bound up in the statements expressed just above. On casual reading they may appear arbitrary to anyone who does not have first-hand knowledge and long experience in the highly specialized professional business of medical education as conceived in the present time and as can be projected into the future. They are made here out of fifty years of personal experience as well as lifetime study of the history of medicine and education for all recorded time.

For instance, the study of anatomy is no longer just a matter of dissecting a cadaver; a department of physiology of a modern medical school is no longer just a place for lectures and for some simple demonstrations to furnish a basis for an examination upon what a student remembers of what somebody else has said. A modern department of pathology is far more complex than an entire medical school operation of just a few years ago; in its many, varied and intricate relations and ramifications, as the bridge from basic science to applied patient care, it cannot be satisfactorily divided for separate operation of a two-year school. Without connection with a four-year co-ordinated course it could not function as it should, nor can the clinical courses (patient care) function satisfactorily except in co-ordination with the basic medical science departments *all the way.*

It has not been long ago that clinical teaching (hospital and clinic patient care) was done practically entirely by private practitioners, and in wards and clinics of hospitals not owned and operated by the medical schools.

While practically all medical schools still—and I hope and trust always will—maintain a full quota of select private practitioners in their faculties, as essential to a well rounded preparation for a medical career, practically nowhere now can a medical school depend upon that element to carry the heavy and increasing burden of modern organized clinical teaching. The life of a private practitioner is fully consumed in his primary business of medical practice; no matter what his qualities and qualifications may be, no matter if he would have been a first rate member in academic medicine had he chosen that career, he does not have the time demanded in present day medical school responsibilities. In fact, the greater his calibre the less he can devote himself to what amounts to an avocation.

Although some private practitioner faculty members serve medical schools on a "part-time" basis, and are proportionately salaried, most of them are on a "voluntary" basis, not salary compensated.

Up to about 1937 the Medical College depended entirely upon private practitioners for clinical teaching. It began then the addition

of "full-time" (vocational and salaried) members who had prepared for academic medical careers; at first only two or three, now grown to over eighty, about half the major clinical staff. Today only one department is headed by a "voluntary" member. As an historical note—the present writer was the first full-time member appointed to the faculty, in 1913, when the Medical College became a state institution; now there are about eighty in all departments. This note is made here as relevant to the questions concerned in the proposal of another medical school.

The primary and indispensable teaching faculty of the present day is composed of vocational people, men and women who have chosen "academic medical" careers, and who have prepared themselves for that life. Well qualified and desirable members are in scarce supply and great demand; usually they would not be interested in a two-year school if they were qualified to do better for themselves.

The same kind of development relates to the facilities for modern clinical teaching. Like practically all medical schools up to the present era, the Medical College depended upon wards and clinics not owned or operated by it. Except in a few special cases, where control is essentially the same as under ownership, no medical school uses any other than its own hospital(s) or clinics except as some grade of auxiliary. Virtually all of them have provided their own clinical facilities, and any new school must take into its calculation the costs of building and operating hospital and clinics, as well as basic science departments, administrative quarters, research space, library, etc., all designed, equipped, and staffed and serviced, as the essentials for acceptable and successful medical school launching and development. To build a new medical center complex requires wise planning—and *some doing;* those recently built, or now building or planning, have taken all of this into account. They are fortunate in having the opportunity to do the job "from scratch," as an interwoven cohesive establishment.

To depend on resources beyond those in hand or guaranteed by such responsibility as would amount to the same thing would be unwise; to count on the large financing involved in planning, construction, equipping, staffing and operating without such guarantees would be stupid, not warranted by such existing conditions as would justify a "crash program," as if in an extreme emergency.

While the Medical College had its over-all plans ready beforehand, it did not move into its sixteen million dollar (and more) program of the recent-present era until it had the money "bonded." Neither did the schools in Chapel Hill, Augusta or Gainesville (Florida), I feel certain. Duke, of course, had its "money in the bank," so to speak.

The suggestion which is reported to have been made recently that "community hospitals" here and there be tied in to provide the clinical years of the regular four-year course does not fit the "modern" concept and trends in medical education. The evolution of the highly organized medical center, complex as it is, and yet tightly interwoven in its many co-ordinated parts, could hardly be carried out with the clinical teaching facilities so dispersed.

While other hospitals and clinics than the school's own may be used as important adjuncts, they must be physically located and operationally associated in such ways as to make even special or auxiliary use practicable. In very special circumstances such associated institutions may even be a major clinical teaching facility of a school of the highest grade. However, nowadays that order of development in connection with a new state school would indeed be rare. In no present view can such a situation be seen, or realistically foreseen, in and for South Carolina. And that is no reflection upon the hospitals in the State. From the smallest to the largest, and in over-all estimation, South Carolina's hospitals, and the doctors who staff them in medical care of the people, are second to none, and superior to some. To place upon them, however, dependence for the absolute essential for the education and training of doctors of medicine of this day and the future

— *clinical teaching* — would be such an unrealistic concept as to be fantastic. If that suggestion is a worthy one, then the entire development in medical education of the past half century is wrong — and should be scrapped.

Another suggestion that has been made, that existing medical schools of the region be lined up for transfer of the students of the proposed two-year school for their last two years of the course, is itself speculative and unrealistic. It has always been the case that individual students may transfer from one school to another, provided they may individually find such an opportunity and prove acceptable. It has even been the case that some of the larger schools have heretofore expected to receive accretions of that sort. However, that opportunity has grown progressively slimmer in recent years; that is one of the reasons that certain two-year schools were able to demand provision for expansion into a full grown four-year operation.

That proposal, or plan, cannot be counted upon; from word in hand, the commitments reported to have been made recently by one of the promoters of the proposed second medical school, that certain medical schools of this region would absorb the number of students proposed for the new school, evidently had no basis in fact or prospect.

As to the need for more medical schools, so far as South Carolina is concerned just now this does not appear as pressing as is being claimed lately over the nation. Certainly it does not present itself in such extreme terms as to justify a "crash program," come what may in cost or unexplored consequences; not even a hurried decision.

There was a time when the conditions were near critical. That was a war time period, when our doctors were being taken in numbers for military service for years, before, during and after. It was at a time when the Medical College was turning out less than forty graduates a year, and only twenty per cent of its admissions were, by military edict, allowed to come from South Carolina.

In recent years one hears of no such pleas as came during that period, begging that doctors be found for communities where the people had none locally at hand, or at least not as many as they had been accustomed to. Occasionally there is a call now from a place which *might* support a doctor in practice; more often such inquiries are from locations where there had been a doctor in "horse and buggy days" or conditions. Cross roads communities once had doctors; now many such locations will remain unoccupied, at least by private physicians on their own livelihood—and this for good reasons. Our doctors are now aggregated in the cities and larger towns, also for good reasons; there seems no dearth of doctors in such locations, and there are no such circumstances in sight, or on the horizon as to indicate that this distribution of private enterprise physicians will change much any time soon. The shortening of distance by the readiness of transportation and the quickness of communication, along with the provision of facilities which can only be made in centers of population sufficient to furnish them, have made radical changes in the practice of medicine.

The Medical College, in response to the need that was definite in the nineteen forties, doubled its medical class size, and also took over completely and increasingly the training of registered nurses, but only so much as its expansion of teaching facilities justified. It can now produce up to eighty doctors a year.

As for demands of further increase of enrollment, there is room for at least two schools of thought. The unqualified statement that "we need more doctors" is frequently heard, even in South Carolina; usually on a population basis. The National Government spokesmen have been loudly sounding that note for twenty-five years or longer. At the same time the mushrooming agencies of that same Government have been taking large numbers into their own career positions.

Doubtless the antipathy (justifiable as that may be) of the practicing profession and others, for any proposal even smacking of "socialized medicine"—meaning really "governmental medicine"—would block any idea

of Federal schools for providing the large, and increasing numbers of government career medical people required. Why not? Why should South Carolina assume, or continue to carry, a part of that mounting Federal demand? Let those who wish answer that question, taking serious account of the present situation and the trends in Federal service medicine in the variety and quantity it presents. The writer believes he knows beforehand the answer that would be given by "organized medicine," but is also aware of the subterfuges in some minds to accomplish the same purposes by indirect means.

Much has also been said on the question of the desirability of opening the doors of medical education in South Carolina to enrollment of students from outside the State. As a matter of fact there is no legal or regulatory restriction about that question now, nor has there ever been. Suffice it to say here that when and if sufficient qualified applicants are not forthcoming from its own people, the admitting authorities of the Medical College would undoubtedly fill its quota by taking some from outside — *provided the requirements in quality and qualifications were met.* Actually twenty-one of the forty-one publicly owned (state) medical schools admitted last year either no students from other states, or so few that it was merely a token, of little significance. (See *J.A.M.A.*, Nov. 11, 1961)

However, there is something to be said on the other side of this question. South Carolina has not really suffered the deterioration of numbers or quality complained about in other sections. In fact, the number of desirable applicants here has steadily improved through the years. There is no such situation as would justify "beating the bushes" for students, as is being proposed elsewhere. Further, it is a very real question as to whether even "bright" students should be enticed into medicine against their inclination to follow some other career. Although it is not so much talked about in this era of materialism, medicine still is a "calling"; it is not, and I hope never will be, a business, primarily entered for profit.

Experience is a wonderful teacher. In fifty years of participation in medical school admissions, the enrollment of a student from outside the state who was outstanding here and thereafter has been a rare occurrence, and usually was attended by very special circumstances on the part of the student. On the other hand, (with abject apologies to a few individuals I would like to name) such admissions have usually brought the "culls"—and would tend to do so again. The outstanding experience came during World War II, when the Medical College enrollment was *drafted,* and we were permitted to accept only twenty per cent of our own selection. The eighty per cent enrolled under the Federal system didn't want to come here in the first place, and we would not have accepted them had we not been under orders in the second.

The argument that students from the outside would tend to settle here after graduation is a fallacy; if one of those militarily enrolled students ever located in South Carolina, it is not in my recollection just now. On the other hand, most of our own young people who go to other medical schools return to the state. That is a strong contingent, and I hope always will be. In turn we furnish doctors to locate in other states—and point with pride to a considerable number who have attained prominence—but we also have great satisfaction in maintaining a leading position among all of the states in the high proportion of our graduates who locate for life at home. Furthermore, to meet the charge that too many doctors are specializing, our graduates furnish the backbone of medicine throughout the state in general practice. We of course provide fully accredited postgraduate preparation in the specialties too, eighty a year at the present rate, not counting interns or research fellows. Many of these come from other schools, and *they* provide the main contingent from the outside who tend to locate in South Carolina.

Perhaps this is a better form of guarding against professional "inbreeding," if there may be such a thing at all, rather than by deliberately bringing in undergraduate students.

On that question, let it be recorded here that professional inbreeding is best guarded

against at the level of the faculty — the breeders, you might say, of ideas, attitude and knowledge. Of the present heads of the departments, thirteen of the eighteen on full-time professorial status are graduates of other medical schools, and there are many more of like origin now in the other grades of the full-time staff. Not all schools could show a comparable ratio. It might well be that this importation of professional leaders is better for the introduction of new professional blood than is bringing in students from here and there over the country. At any rate, even biological inbreeding is not scientifically all bad; the famous Santa Gertrudis breed of cattle was produced by such strict inbreeding as will never (I hope) occur in the human race.

As to the question on the size of medical school classes, the answer is not quite so simple as a former medical school dean is reported to have stated at a recent promotional meeting on the subject held by a chamber of commerce—nor should it be answered in an arbitrary manner for promotion purposes.

True, it has been considered by some that classes of 75-80 are "optimal"; but certain other schools have considered that the number should be limited to around 50. It all depends upon the conditions of a moment, the beliefs of some people—and sometimes upon "whose ox is being gored."

The ideal would of course be a class of *one*, guided and tutored by an individual instructor in each departmental subject or specialty—say some ten instructors to one student. The sublime thereby becomes the ridiculous.

Personal attention of faculty to students does, of course, become less and less as the number of students per instructor exceeds ten or so; but as long as the numbers are in about that proportion and the proper facilities are provided per student, classes of one hundred or even more can be handled satisfactorily. After all, within reasonable proportions, the result depends upon the instructor. Some instructors cannot provide such personal attention, others can give it to more than is generally considered a good quota; it is a notorious fact that many medical professors do not even know their students, and that a famous professor sometimes may not even be recognized by students—they may never have seen him.

There never has been any question as to whether South Carolina needs its state medical school, as that essential unit of its "State university system." Otherwise there would undoubtedly be a quite inadequate situation in health and medical care of its people. Only eleven of the fifty states, all of which, incidentally, rank higher than South Carolina in per capita income, have not made this provision. On the other hand, very few have undertaken more than one school, and those few with much greater resources and population than South Carolina. Virginia is the only state in the entire Southeast with even two state schools, and that probably by reason of "political" and special circumstances. Two states with resources and populations of the largest, Pennsylvania and Massachusetts, have no state schools, although they may make appropriations to privately operated schools.

New York has three, Michigan has two (one recently taken over), California has two, and may be launching a third, and Texas has two and appears to be designing a third. The resources and populations of these states are to be calculated in multiples of the assets and needs of South Carolina.

We are considering here, of course, state medical schools, and the situation in South Carolina. Let it be stated with utmost sincerity that the establishment of *another school (or more) of non-state (private) and appropriate ownership and operation would be more than welcome; from all viewpoints that would be fine.* There would be mutual competitive as well as cooperative advantages to both. I am on record in that judgment in several conferences where I have been accorded the opportunity to speak, beginning over two years ago. I would have the same feeling about more than one State school under circumstances similar to those already cited, in population, resources and *actual* need.

North Carolina has two privately owned medical schools, besides its state school. Vir-

ginia has no private school, but two state schools. Maryland has one, besides its private school. Kentucky has one of each, as has Tennessee, Georgia, Florida and Louisiana. Alabama, Arkansas, Oklahoma, West Virginia and Mississippi have one state school each, and no other. These are states in geographic location in our quarter of the country. For further comparison, if that be desired, Iowa, Nebraska, Washington, Oregon, Colorado, Utah, and Indiana, each has only one state school and no other. Among the states in which no medical school is located are Maine, Rhode Island, Delaware, Montana, Wyoming, Nevada, Idaho, Arizona and New Mexico. The last named is reported to be in process of developing a state school.

In summary, according to the listing of the eighty-six schools by the *J.A.M.A.*, Nov. 11, 1961, including the District of Columbia and Puerto Rico along with the states: there are 11 states in which there are no medical schools at all, and all have per capita incomes above that of South Carolina; there are 18 states which have publicly owned and operated medical schools, and no private school; seven states have one state school and one private school each; two states (Michigan and Virginia) have two state schools each, but no private schools; four states have more than one state school each and also have private schools. (California two state, three private. New York two state, eight private. Texas two state, one private. Ohio two state, one private); five states including the District of Columbia have no state schools, but of private schools Pennsylvania has six, Massachusetts three, District of Columbia three, New Jersey one, New Hampshire one; four states have one state school each, and more than one private school. (Illinois four, Missouri two, North Carolina two, Tennessee two.)

Earlier in this writing it was pointed out that the history of medical education shows that the founding of medical schools, or at least the instigation of the idea, was mainly by doctors. That applies to South Carolina all the way. In the origin of the Medical College of South Carolina, that influence was predominant, as it was in the reopening of the school in 1865. There is no reason to doubt that doctors furnished the inciting stimulus in establishing the short-lived school in Columbia in 1866-67.

On the other hand, instances of opposition to the establishment of a medical school or to providing full support to an existing school are by no means uncommon generally. Usually the reason for such opposition is obvious, commonly concerned with competition of communities for location of the school. There is evidence that certain medical factions resisted the passage of the legislative Act of 1913 establishing the Charleston school in State ownership, and it is well known that medical groups opposed the Medical College in its bid for opportunity to carry out its great program of the mid-forties.

The present proposal of another State school in Columbia originated with a group of doctors there through the Columbia Medical Society, and it is said that certain doctors of other locations have joined a movement for another medical school, but in behalf of their own cities.

It is freely acknowledged, with appreciation, that organized medical groups of responsible stature should have a voice in the question of establishing a medical school, particularly a state school and especially a second state school. However, in the present era there has arisen a voice that takes precedence over that of the rank and file of medicine. When most of our medical schools were established there was no vocational career branch of the profession, such as the *medical educators* who have come into being in recent time. Members of that specialty should be the judges in decisions upon questions about medical education. That is to say, that in the last analysis competent local judgment should control local matters, subject to national level assistance, support and mutually applied policy. The agent of local responsibility is the administrative authority of the local school, the national responsibility rests with the organization composed mainly of the many medical school heads. The experience

of the Medical College of South Carolina has run the whole course of evolution of medical education in this country, from the conventional local manner of origin then in vogue to cooperative association in national organization of all "approved" medical schools. As the medical unit of the State's "university system" it assumed the responsibility of providing for South Carolina the best in "health and medical education, training, research and service" that could be afforded; it should be fully supported in that trusteeship. It is the local judge of what is best for the State—and it is *competent.*

While the idea of establishing a second state medical school was conceived by local doctors of the interested communities, it has been passed to civic interest and *employed* promoters. That makes of it a promotional campaign, analogous to the common course pursued in trying to induce an industrial enterprise to locate in a certain community. It has even been subject to political maneuvering. That is all a wrong approach; it tends to set selfish local or private interest of several varieties above the general welfare in the most vital matter of all human existence. The subject is the one most difficult for people at large to analyze and judge; it is the one in which they are most easily misled.

It is high time for the Medical College of South Carolina, as the authority responsible to the State and all of its people, to make its own analysis of the needs, its conclusions of how best to meet them, and its recommendations and plans for the era in view and that may be realistically foreseen. History and accomplishment show that it is competent, informed, and conscious of all the problems concerned.

BOOK REVIEWS

THE STORY OF X-RAYS FROM RONTGEN TO ISOTOPES. Alan Ralph Bleich. Dover Publications, Inc., New York, New York. $1.35.

Author Bleich has written in an easily readable style a book which covers in a condensed manner the wide scope of radiology from its history through its present usage and future possibilities. The text is generally interesting and is informative on a level which seems most suited to the lay public and those in the allied sciences of medicine.

Robert Jordan, M. D.

PROBLEMS IN SURGERY. By Frank Glenn, M. D. Illustrated. C. V. Mosby Company, St. Louis. 1961. $16.50.

This book consists of a series of case reports gleaned from the Surgical Grand Rounds of the New York Hospital — Cornell Medical Center. The subject matter is of broad surgical interest. In general case presentations are pithy with inclusion only of pertinent positive findings. Differential diagnosis and alternate methods of management are not stressed. Illustrations and printing are adequate. This volume is of interest to those who enjoy case reports but is not recommended for the student, house officer or busy practitioner.

Richard G. Price, Jr., M. D.

FINGERPRINTS, PALMS AND SOLES, AN INTRODUCTION TO DERMATOGLYPHICS. Harold Commins and Charles Midlo. Dover Publications, Inc., 1962, New York. $1.95.

While this book has little direct appeal to the physician, there is much material in it which should be of interest in the matter of identification of patients by fingerprinting.

J. I. W.

CLASSICS OF CARDIOLOGY. VOLUMES I AND II. Fredrick A. Willius and Thomas Keys. Dover Publications, Inc., New York. $2.00 per volume.

These two volumes are excellent examples of the inexpensive books produced by Dover Publications. Well printed and illustrated, they include a collection of the classical contributions which have built our present knowledge of cardiology. They should be desirable acquisitions for all who are interested in this specialty or the history of medicine in general.

J. I. W.

Medical College Clinics

ELECTROCARDIOGRAM OF THE MONTH

Cardiac Pacemaker

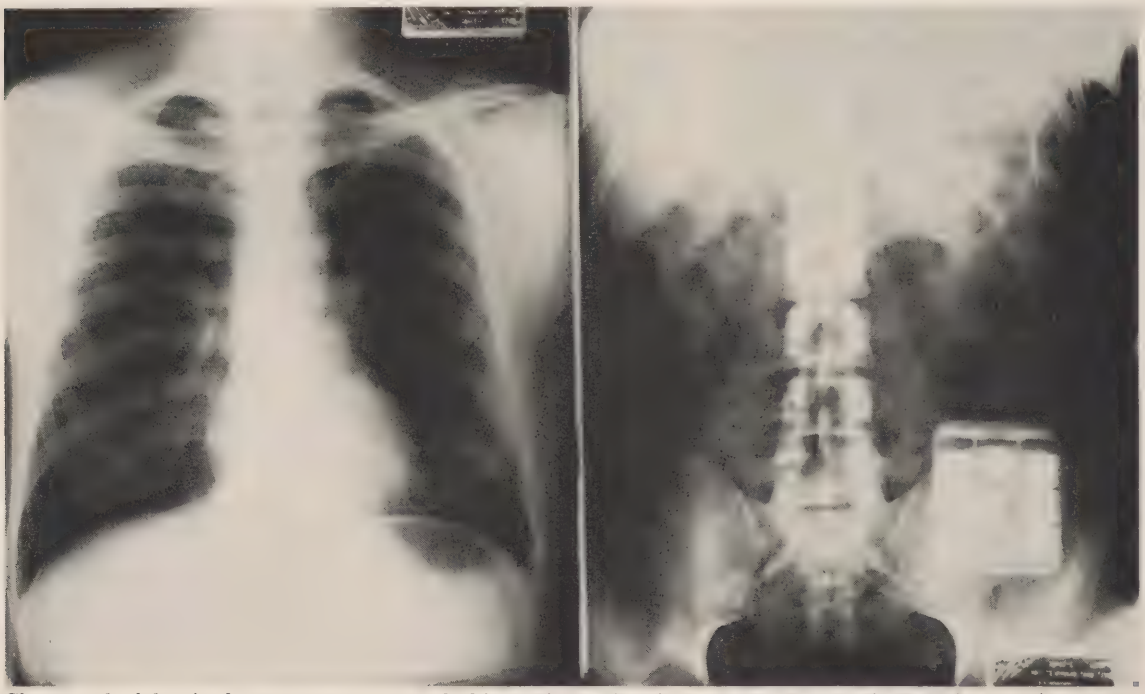
DALE GROOM, M. D.
Department of Medicine

Case Record. These electrocardiograms were made on a 37 year old minister who was referred for cardiac evaluation because of the complaint of "blacking out". Episodes of transient vertigo and weakness had begun at age 19 while he was in military service where a diagnosis of "two to one block" was reported. Subsequently the attacks had become increasingly frequent and severe, often accompanied by momentary pain in the mid-chest which awakened him at night. Ultimately as many as twenty or thirty attacks occurred daily, ranging in severity from mild dizziness to severe pain and dyspnea—all entirely unpredictable and lasting no longer than a few seconds. At no time did he experience convulsions or complete loss of consciousness. Apparently the episodes were so inconspicuous that he had successfully concealed them from his congregation. Although there was no causal relationship between his attacks and physical exertion or any other known activity, the chest pain, when it occurred, tended to be worse following exertion and his tolerance for exercise was at all times quite limited. The only item in his past history suggestive of rheumatic fever was an account of several instances of spontaneous epistaxis in adolescence.

Cardiac examination was not remarkable except for the rate and rhythm. Usually his pulse was fairly regular at 35 to 40 beats per minute but rarely it would increase for brief periods to 60 or more, irrespective of any stimulus. The heart was of normal size and contour on the chest roentgenogram.

Several medications were tried from time to time, the most effective proving to be Isuprel used sublingually 15 mg. q. i. d. On that schedule he experienced fewer attacks (actually being virtually free of them for several days) but complained of much tension and insomnia from the drug. Nitroglycerin, as might be expected, gave no relief of the chest pain. It was chiefly because of this recurrent and unpredictable pain that he decided to undergo surgery for implantation of an electrical pacemaker. The surgeon's* operative note follows:

"The chest was entered through a primary left anterolateral incision in the bed of the non-resected sixth rib. The pericardium was incised just anterior

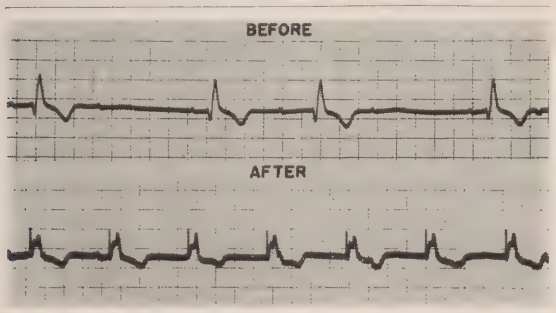


Chest and abdominal roentgenograms of this patient showing electrodes implanted in cardiac apex. Wires lead to transistorized pacemaker powered by mercury batteries and implanted subcutaneously in the anterior abdominal wall.

*Dr. Dwight C. McGoon, Mayo Clinic, Rochester, Minn.

to the phrenic nerve. Unfortunately, it was noted that the phrenic nerve lay unusually far anteriorly in this patient. The small portion of the left ventricular myocardium which was exposed appeared normal as did the coronary arteries in this area. A transverse incision was made in the left mid-abdomen and a pocket was created between the subcutaneous fat and the fascia. This pocket was just large enough to accept the pacemaker. A tunnel was created subcutaneously across the costal margin and wires were led through this tunnel and through the sixth intercostal space into the pleural space. The electrodes were then implanted in the myocardium about 1 cm apart, the needles being passed from superiorly inferiorly. Each wire was then turned and resutured into the myocardium with No. 000 silk sutures at each point of entry and exit from the heart. Each seemed securely anchored in place. The pacemaker functioned very nicely although for the first several moments marked cardiac irregularity was noted and for one instant ventricular tachycardia occurred. The pericardium was closed around the entering electrodes after making a 1 cm counter incision over the posterior aspect of the peritoneum to allow drainage. The wires were also anchored with several sutures to the pericardium itself. A large loop of wire was then gently formed along the mediastinum thus avoiding any localized areas of flexion. We were distressed to find that the current spread into the phrenic nerve rather easily. This was corrected by freeing the phrenic nerve from the pericardium and transplanting it posteriorly into a more nearly normal position. Pericardial fat in this area was then interposed between the phrenic nerve and pericardium. When this was accomplished stimulation of the phrenic nerve no longer occurred."

The lower tracing was made two weeks after operation when the patient resumed his pastoral duties. As yet (two months later) he has had no recurrence of the former attacks.



Electrocardiogram—Both of the strips illustrated are of lead V_1. Long strips of tracing prior to surgery disclosed variable degrees of AV block but predominantly a complete dissociation of atrial and ventricular activity. Pauses in the idioventricular rhythm of 2 to 3 seconds duration were frequent.

After operation (lower tracing) an additional complex is added, that of the extrinsic electrical pacemaker which produces the impulses of extremely short duration immediately preceding each QRS complex. Its rhythm is precisely regular at a rate of 72. There is practically no delay between the electronically created impulse and the ventricular response which it evokes. Since implantation of the electrodes was in the area of the apex, depolarization of the ventricles proceeds upward toward the V_1 position producing an entirely upright QRS complex which understandably differs from that in the preoperative electrocardiogram. The heart's own pacemaker continues to initiate P waves in an unaltered regular rhythm.

Discussion—Stokes-Adams attacks are a common accompaniment of complete AV block. Effectively disconnected from the normal pacemaker, the ventricles carry on by beating at their own innate rhythm which is usually fairly regular at a rate on the order of 40 but which unfortunately may be interrupted by long periods of asystole caused by momentary failure of the ventricular myocardium to maintain its pacemaking function. Interruption of the circulation for no more than a few seconds causes transient weakness and giddiness. Longer intervals of asystole produce syncope, loss of consciousness, convulsions and, if for more than a minute or two, death. The ventricular myocardium is a relatively poor pacemaker, too slow and unreliable — a court of last appeal, as it were, after failure of the higher levels of the conduction system. Nevertheless some patients live on for years with tolerable circulation in the face of complete atrio-ventricular block with idioventricular rhythm.

Isuprel, ephedrine and other sympathetic drugs serve to stimulate the myocardium and increase its inherent rate as well as perhaps reduce the likelihood of asystole. The use of digitalis has been said to be hazardous in this disorder because of its vagal effect but how digitalis could impose any threat by depression of an already completely blocked AV node is difficult to understand. Certainly quinidine or any measure which might substantially decrease the irritability of the ventricular myocardium would be definitely contraindicated.

An additional feature of idioventricular rhythm is its independence from normal physiological controls. Not only is the heart rate slowed to 40 or so but there is little or no compensatory increase in response to demands for increased cardiac output. Hence the rigid limitation of exercise tolerance. More than minimal physical exertion in this patient, who ostensibly had an otherwise normal cardiovascular system, produced dyspnea, claudication and fatigue. Even with the extrinsic pacemaker his heart rate remains independent of physiological demands although the controlled rate of 72 allows considerably more circulatory reserve.

The calculated minimum life of this transistorized

pacemaker with mercury batteries is in excess of three years at which time it will probably be replaced. Meanwhile any failure of it could be expected to leave the patient in no worse a situation than he was before its installation.

An interesting alternative approach to the problem is the implantation of autografts of thyroid tissue or adrenal medulla into the ventricular myocardium. Tablets of tri-iodothyronine capable of prolonged sustained release have also been implanted in experimental animals. The rationale is that the small area of myocardium surrounding the endocrine transplant is stimulated by the high local concentration of hormone to become the dominant pacemaker for the ventricles and thereby bring about a faster heart rate. Preliminary reports of endocrine pacemakers[1] indicate some compensatory acceleration of rate in response to exercise.

Etiology of the conduction defect in this case remains obscure. The late onset of symptoms and the apparent progression in degree of block through the years is against a congenital lesion. Of the acquired types of permanent complete AV block, ischemic and rheumatic disease are the most common causes. Neoplastic,[2] infiltrative and degenerative processes account for a few. Only a minute amount of tissue need be damaged to render the AV node completely non-conducting. Especially in those cases with Stokes-Adams attacks, control of cardiac function by means of an extrinsic pacemaker may be lifesaving and constitutes a practicable though partial solution of a disorder which is attended by considerable disability and mortality.

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2. Groom, Dale: Complete AV block. J S Carolina Med Assn. 53:216, 1957.

DERMATOLOGICAL DON'TS

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CASE V—Chronic Paronychia from Monilia

White, Female, Age 35.

HISTORY

Patient is mother of five small children.

She has no help with housework and is constantly involved in "wet work".

Six months previously she developed a tender area at the base of one nail.

The inflammation encircled the base of the nail, tended to come and go with periods of acuteness.

During the past six weeks similar lesions appeared on five other fingers.

Two days before the patient was seen, three of the lesions had become acute, with redness, swelling and tenderness.



PHYSICAL EXAMINATION

The proximal nail fold and medial and lateral nail folds of four fingernails were erythematous, swollen and tender.

Two of the nails showed a greenish discoloration at the lateral fold.

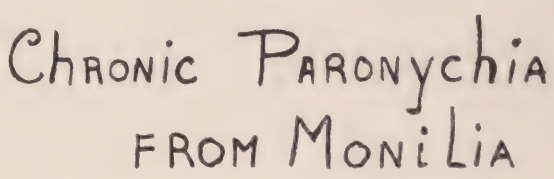
The cuticles of the involved nails were well separated from the nails.

One of the nails was ridged and distorted but there was no heavy debris under the nail.

DIAGNOSIS

CHRONIC PARONYCHIA — ETIOLOGY — MONILIASIS.





TREATMENT

DON'T

1. Don't give griseofulvin.
2. Don't treat with local antibiotics with neomycin.
3. Don't give systemic antibiotics.
4. Don't widely incise the lesions or remove nails.
5. Don't use rubber gloves.

DO

1. Do clean thoroughly with tincture of Zephiran, allowing it to go under the cuticles.
2. Do apply nystatin or amphotericin-B ointments such as: Mycostatin cream, Mycolog cream or Fungizone cream.
3. Do continue treatment until the cuticles have tied down.
4. Do use hot soaks with normal saline for acute swelling and pain.
5. Do advise patient to avoid deep hot water as much as possible—use hand mop for dishes, etc.

POISONING OF THE MONTH

by

MARGARET Q. JENKINS, M. D.
Department of Pediatrics

T. D., 24 month old white female, ingested approximately 1-1½ ounces (300-450 mg.) of Novrad cough syrup. The child obtained the medicine bottle from a drawer in the bedroom and was alone in the room at the time. Ingestion occurred at approximately 10:15 A. M. and the patient was immediately brought to the doctor's office. She walked into the office and appeared to be perfectly normal at the time; however, approximately 20-25 minutes after ingestion, a very fine tremor of the hands and unsteadiness of gait were observed. Lavage was performed with a nasogastric tube and 50-60 ml. of stomach contents were obtained. This was red in color with the same odor as Novrad. Approximately 800 ml. of water was used to lavage the stomach further. At the end of the procedure the patient developed a pronounced, uncontrollable trembling involving all extremities, associated with marked agitation. It was noted that the tremors increased markedly when she was placed in the upright position and tended to diminish somewhat when lying supine.

Blood pressure was 105/75, mm. Hg. Pulse 120/min. The pupils were not remarkable. Respirations were unchanged. Approximately one hour after ingestion, she had the onset of vomiting which continued every 15 minutes for the next 4½ hours. A very small amount (30 mg.) of phenobarbital was given intramuscularly. Both the vomiting and marked tremors decreased around 4½ hours after ingestion. A deep sleep followed, but the patient could be aroused from this, and the fine tremor persisted each time she was placed in an upright position. The tremor subsided and the final disturbance noted was a slight unsteadiness of gait which lasted until 7½ hours after ingestion, after which time the patient was playing and appeared completely recovered and happy except for a ravenous appetite.

Novrad (levopropoxyphene) is an antitussive, synthesized by Eli Lilly Laboratories and has been available for only a few months. The only side-effects previously noted in humans are nausea, urticaria, drowsiness, "jitteriness" and dizziness. The director of the medical division of Eli Lilly & Company stated that in experimental animals with the administration of large doses, coma followed by cardiac arrest has occurred and for this reason nalomorphine and barbiturates are contraindicated. The peculiar tremors observed in this patient have not been noted previously with this drug and the vomiting was more severe than might be expected from previous reports.

[Spontaneous Rupture of the Esophagus page 334]

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Editorials

Poison For The Public

As poisoners, the old Borgias were obviously pikers, in that they poisoned only a few persons obnoxious to themselves. The modern poisoner, open and aboveboard and regarded as a public benefactor, takes his liberal toll of life at all levels with the excuse that he is destroying insects harmful to various plants or plain mosquitos which do no more harm than to excite a few extra slappings from their victims. As soon as an unusual swarm of mosquitos from an old breeding place affects a community, the citizen who considers himself well informed cries for the fogging machine and the destruction of the pests, giving no attention to the accompanying destruction of beneficial species of insects and the consequent death of birds, household animals, and even people.

Of late man has been making violent efforts to control his environment more and more, and the current popular programs for obliterating unpleasant insects have done something to make man temporarily a little more comfortable and much to make man's future more doubtful. New compounds used for fogging and dusting are toxic not only to their target species, but to nearly anything living that is attacked by some of the 600 new "pest killers" now in use. A temporary abatement of the numerical strength of the insect nuisance has little lasting effect, for the undesirable insects have an undesirable way of developing immunities and undergoing mutations which simply render the whole process futile. Thus under ordinary conditions the benefits are small and the dangers are great. Reports of no improvement in the insect problem after repeated foggings are common.

We have few occasions in our part of the world for apprehending mosquito-borne disease as a real threat. Malaria is now a rarity, practically unknown, and yellow fever and other insect-borne diseases are no longer with us, thanks be to various things over and above fogging.

Serious poisoning and even death of human beings from some of these new insecticides is not uncommon. Obviously the persons who are nearest to the sources, or those people who handle the substances, are much more liable to difficulty. But the broad threat of the situation lies in what seems to be the documented fact that these substances become so widespread, getting into food, water, animals, soil and other important sources of human nourishment, that slow but usually unsuspected damage gradually builds up in that part of our population who live in areas where spraying is used widely.

Rachel Carson, who wrote a few years ago the very interesting and popular book "The Sea Around Us," has written a series of articles in the *New Yorker* which paint a dreary and gruesome picture of the effects of what most people consider to be a beneficial process. They are entitled "Silent Spring." The author gives reasons to think that there may be not only acute poisoning but frequent genetic changes, and cites instances in which handlers of certain insecticides have become sterile. Whether this kind of contamination and cellular change is one of the sources of our increasing number of congenital anomalies and cancer in children is a not undebatable question. These articles are extremely well worth reading. They give food for thought which might be nourishing, even if depressing, to all of us.

It is time we came out of the mental fog which promotes our endorsement of atmospheric fogging.

Mail Order Prescriptions

The patient who orders his prescription by mail must be pretty much of the same class as the reader who gets his medical advice from some medical columnist of doubtful status. The possible dangers in this newly suggested arrangement are rather obvious, including the difficulty of deciphering some of our choice handwritings, delay in delivery of

medicine, and the absence of the personal relationship between the physician, pharmacist and patient.

While the savings may be of some little consequence, it is not likely that any great differential can be achieved by this method of dispensing drugs.

Senate Defeats Medicare

The New Frontier suffered another severe defeat on July 17 when, at 3:15 p. m., Senator Robert S. Kerr (D., Okla.) introduced a motion to table the Anderson-Javits Amendment to H.R. 10606 and the Senate approved the motion 52-48. Health benefits for the aged financed through Social Security taxes were defeated primarily by the Democrats themselves.

If the Congress, controlled by Democrats, were in favor of New Frontier legislative proposals, the bills would go through. The Administration is not justified in blaming the American Medical Association, the Republicans, or even the southern Democrats for the Anderson-Javits defeat. Not when the Senators from Oklahoma and Virginia and even Senator Randolph of West Virginia opposed the Administration.

Since the issue of Federal support for health care benefits for the aged is by no means a dead issue, we should look closely at the reasons back of this week's action in the Senate. Why did 21 Democrats—one-third of the 64 Democrats in the Senate—vote against a key Administration proposal? These are the reasons which came out during more than two weeks of debate:

1. The legislative device employed by Senators Anderson and Javits was unconstitutional;

2. The Amendment was not a medical care plan as claimed;

3. The Kerr-Mills law had not been given a fair trial;

4. Social Security financing of a compulsory health insurance scheme is unwise and may jeopardize the entire Social Security structure; and

5. Compulsory health insurance for the aged is a first step toward the nationalization of medicine for the entire country.

In a little over an hour after the Anderson-Javits Amendment had been defeated, the President appeared on radio and TV angrily denouncing the vote as the work of the Republicans and "a handful of Democrats." In almost the same breath he blamed the American Medical Association. He was willing to place the blame anywhere but where it belonged—on himself, on former Secretary of HEW, Abraham Ribicoff, on Assistant HEW Secretary Wilbur J. Cohen, and on Senators Anderson and Javits.

From *Challenge to Socialism,* July 19, 1962

The President and The Senate

There is little doubt that the Administration will take the issue of medical care for the aged to the polls in November. Indeed, we believe the Republicans will wish to do so too. For the issue is now clear. It has been debated on the Senate floor as few other issues have. The question that will be put to the American voters next fall is whether or not the elderly, or any other segment of the population, or the entire population wishes to abandon the private practice of medicine and the free enterprise system insofar as health insurance is concerned.

Of course, the Administration will make believe the issue is something quite different. Now is the time to examine the varying claims and charges that have emanated from the White House. We shall bring them together, put them down in black and white, and analyze them. Then, as the opponents to the Welfare State and to nationalized medicine make their speeches, write to local editors, appear on radio and TV they will have their arguments organized and their documentation at hand. This is the time for preliminary work, for assembling material, for developing arguments and for gathering documentation. Then take the issues to the polls.

The Administration claims that it was a "handful of Democrats" who joined with 31 Republicans to defeat the health benefits proposals. Most recently the President presented the situation in reverse. He said at his news conference on July 23 that "Two-thirds of the Democrats voted for it, a third of the Demo-

crats voted against it. About six-sevenths or seven-eighths of the Republicans voted against it. So this combination of almost total Republican opposition with a third of the Democrats defeated us by 52 to 48.

"Now, the issue in November, every seat that is contested between Republicans and Democrats, really, I would say, in 80 per cent or 90 per cent of the cases, would be between those who oppose medicare and those who are for it. So there isn't any doubt that there is in a party as large as the Democratic Party those that do not support a good many of the programs.

"The alliances may change but, of course, we lose a third or a fourth, and we have since 1938, but the fact of the matter is this Administration is for medicare and seven-eighths of the Republicans are against it. That seems to be the issue."

Challenge To Socialism

Measles Vaccine

A new live measles vaccine which was found to give nearly 100 percent protection against the disease with only a single inoculation was reported by Dr. Saul Krugman, Chairman of the Department of Pediatrics at New York University School of Medicine. Dr. Krugman conducted field trials among 4,000 infants and children in the New York City area under a grant of the Health Research Council of the City of New York. He reported the advantages of the live anti-measles vaccine included:

Only a single inoculation is required to provide immunity.

No local reactions, such as redness, swelling or soreness at the vaccination site, has been observed.

The incidence of fever and rash is low and can be further reduced by injection of a small dose of gamma globulin.

Immunity appears to be as certain as that provided by naturally acquired measles.

Amer. Acad. of Ped. News Letter

Miscellany

We note the announcement of a new book entitled "Refining of Oils and Fats for Edible Purposes." We have often heard about swallowing words, but we have never heard about eating purposes. Perhaps this is a new form of nourishment.

While the editor admits freely to lifting material from daily newspapers, there are some things in the papers which he simply cannot lift except for the purpose of dropping them as if they were hotcakes; e.g., "Friday, July 6, Beverly underwent open heart surgery to correct existing triology of the fallot, a reversal of the arteries to the heart."

The Greenville Piedmont tells us that Dr. Lawson W. Stoneburner has been elected president of the Greenville Sertoma Club.

We note the following additions to the Five-Inch Shelf of Books. Perhaps you have seen others yourself.

1. Gold content of the tonsil. How to remove it. by E. E. Entee, M. D.
2. Delaying Actions in Rendering Reports. by Sam the Laboratory Man.
3. How to Find a Resident. by Gee Pee, M. D.
4. The Forty-Hour Week; How to Reduce It. by F. L. Tyme, M. D.
5. Helpful Hints to Stupid Attendings. by I. M. Cocksure, Chief Resident.
6. Do it Yourself Cystoscopy. by Gee! You!, M. D.

Further additions to the five inch shelf of books:

1. My Sweetheart The Tonsil. by E. E. Entee, M. D.
2. The Baby; What's It For? by Dr. O. B. Lucina.
3. Neurological Emergencies; What To Do If You Lose Your Hammer. by Nouveau Neuro, M. D.
4. Break, Break, Break. by Ortho Pod, M. D.

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1962-63

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State Board of Medical Examiners of South Carolina

The State Board of Medical Examiners of South Carolina met on June 19, 1962 at the Columbia Hotel, Columbia, South Carolina, to interview applicants for medical licensure by endorsement of credentials. Fifteen physicians were licensed to practice medicine and surgery in the State of South Carolina. They are as follows:

Dr. Robert Cable, II, is a graduate of the Med. College of Ga. ('56) and is licensed in Ga. He plans to go into the practice of PSY in Greenville.

Dr. Elgar P. Ellis, Jr., a 1955 graduate of Bowman Gray, is licensed in N. C. and Md. He plans to locate in Anderson as anPANES.

Dr. William H. Fraley is a graduate of the U. of Ill. in '58 and is licensed in Ill. He does OBG in Spartanburg.

Dr. William W. Francis, Bowman Gray class of '61, is licensed in N. C. He will be in GP in Pickens.

Dr. James A. Harmon, a 1961 graduate of the Med. College of Ga., is licensed in Ga. He will be in GP in Pelzer.

Dr. Edward V. Hastings is a '44 graduate of Marquette U. and licensed in Ill., Wis., Fla., and Ga. He is a PATH in Aiken.

Dr. Rice R. Holcombe, Med. College of Ga. class of '59, is licensed in Ga. He is in the practice of ANES in Columbia.

Dr. Arthur C. Krepps graduated from Jeff. Med. College in 1957 and is licensed in Pa. He does OBG and is in the USN in Beaufort.

Dr. William S. Lang, Jr. is a '55 graduate of Duke and is licensed in N. C. He is in the practice of ALR, Med. College Hosp. in Charleston.

Dr. Robert P. Linker graduated from the U. of N. C. in 1959 and is licensed in N. C. He is in the practice of ANES in Charleston.

Dr. Cecil J. Milton is a '56 graduate of Bowman Gray and licensed in N. C. He does ORTH and is in the USN in Beaufort.

Dr. Frank G. Osborne, Albany Med. College, class of '44, has certificates from the Nat'l Bd. and N. Y. He is in the practice of DERM in the USN in Beaufort.

Dr. Thomas Z. Stanley is a '36 graduate of Geo't'n U. and has certificates from the Nat'l Bd. and Fla. He is in OM at Chemstrand Corp. in Greenwood.

Dr. D. E. Tribble graduated from Vand. U. in 1954 and is licensed in Tenn. and N. C. He does SURG in Anderson.

Dr. Harry T. Zankel is a '25 graduate of Long Island Med. College and is licensed in N. Y., Ohio, and N. C. He is in the practice of PM at the V. A. Hosp. in Columbia.

State Board of Medical Examiners Licenses 75 Physicians

The State Board of Medical Examiners of South Carolina held written examinations at the Columbia Hotel on June 19, 20, 1962. Seventy-five physicians passed the examinations and have been licensed. There were 68 recently graduated from the Medical College of South Carolina.

The successful candidates are as follows: Drs. David F. Adcock, Jr., Columbia; William R. Ameen, Great Falls; Hal C. Anderson, Timmonsville; John R. Bailey, Anderson; David R. Beckham, Jr., Winnsboro; Ronald D. Blackston, Seneca; Guy S. Blakely, Clinton; Jane L. Blakely, Ora; Charles B. Bobo, Floydale; Frank N. Boensch, Jr., Mt. Pleasant; John J. Britton, Sumter; John P. Brown, Laurens; Charles G. Cannon, Jr., North; Ernest W. Carpenter, III, Greenwood; Imants A. Ceips, Clinton; Paul E. Childs, Orangeburg; Andrew R. Cracker, Charleston; Ina S. Crawley, Ruby; Richard H. Crooks, Greenville; Ercio M. DaSilva, Columbia; William M. Davis, Columbia.

Also, Drs. Charles W. Derrick, Jr., Marion; Rex H. Dillingham, Jr., Lancaster; Doris A. Edwards, Columbia; Bobby F. England, Spartanburg; John S. Featherston, Charleston; Joseph F. Garner, Conway; Ronald D. Gaskin, Charleston; Alan B. Glassberg, Charleston; Joe B. Godfrey, Woodruff; James F. Green, Moncks Corner; John L. Guy, Abbeville; James P. Hentz, Anderson; Cloud H. Hicklin, Richburg; Carl J. Hiller, Greenville; Edgar O. Horger, III, Greenville; Roy E. Hudgens, Jr., Lynchburg; Heyward Hudson, Ruffin; Everett M. Hughes, Union; Archibald W. Hursey, Jr., Conway.

Also, Drs. Manly E. Hutchinson, Jr., Columbia; Douglas W. Jenkins, Mullins; Thomas E. Jenkins, Newberry; Allen H. Johnson, Jr., Hemingway; Ronald V. Lanford, Woodruff; Robert G. Mahon, Jr., Calhoun Falls; Charles R. May, III, Bennettsville; James A. McCord, Charleston; Roy M. McCoy, Easley; Robert L. McDonald, Florence; James E. McFadden, Jr., Lake City; James D. McInnis, Darlington; William E. McLean, Columbia; Ralph Mollycheck, Mt. Pleasant; James D. Morgan, Charleston; Margaret B. Neville, Walterboro; Charles J. Owens, Kershaw; William H. Prioleau, Jr., Charleston.

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The next written examinations of the State Board of Medical Examiners are scheduled for November.

Public Relations

SENATE KILLS MEDICARE
MAJOR KENNEDY DEFEAT

Good news . . . yes! But not a signal to retire from the field. Quotations from two South Carolina newspaper editorials emphasize the need to continue full scale operations against future medicare legislation.

BATTLE LOST, WAR TO CONTINUE

(*Charleston News & Courier,* July 18)

Opponents of the administration's "medicare" bill have won a battle, if not the war, against a program of medical care for the aged based on increases in Social Security taxes.

Commenting on the rebuff to his plan, President Kennedy gave notice that the fight for passage of such legislation will be renewed. He voiced the hope that the November elections will return a Congress that will reverse the veto given by the U. S. Senate.

The issue will figure in congressional elections, and the form that government "medicare" takes will be decided largely on the outcome of the races. Should the liberal bloc in Congress be strengthened the administration's path will be smoothed.

It may be recalled that in 1952 President Truman was urging enactment of a compulsory health insurance plan. It was opposed by the Republican Party. The GOP platform that year said:

"We are opposed to federal compulsory health insurance with the crushing cost, wasteful inefficiency, bureaucratic deadweight and debased standards of medical care."

These dangers are inherent in the program the Senate turned down Tuesday and should be considered in any plan of that nature.

DOCTORS IN FOR MORE TREATMENT

(*Charleston Evening Post,* July 20)

A sorry by-product of the Kennedy administration's drive to put across its medicare program was the unwarranted vendetta aimed at the medical profession.

President Kennedy himself induged in the assault on the American doctors. Lesser politicians, taking a cue from the chief, felt free to have at the physicians without restraint.

The President derided doctors as a group of selfish plutocrats who oppose anything and everything designed to relieve the misery of underprivileged and aged sick. Had a visitor from Mars attended the medicare rally in Madison Square Garden in May and listened to the President, the visitor might very well have concluded that American doctors all have horns and forked tails.

Doctors, like other Americans, have a right to fight for what they think is right. A great majority of them oppose President Kennedy's medicare ideas and they have put up strong resistance.

But their fight is still in the early stages. President Kennedy, in the steel case, demonstrated that he is no amateur in a bare-knuckle political scrap, and that he bars no holds when thwarted.

The image of the American doctor is in for some rough treatment in the months ahead.

"Medicare" becomes an issue again in November when Kennedy takes his case to the people. Use this period to let your community know what is already being done for the elderly indigent in South Carolina under the Kerr-Mills Law. These are highlights. For the complete report write:

Arthur B. Rivers
State Director
State Department of Public Welfare
Columbia, S. C.

GENERAL REQUIREMENTS

Funds from state and federal governments will be used to help persons 65 and over who do not have Old Age Assistance, but whose income and resources will not cover necessary medical expenses and hospital care.

Application—through all county welfare departments by persons in state who meet requirements.

Medical assistance under Kerr-Mills is administered by *one* agency . . . the South Carolina Department of Public Welfare.

Any person may apply. Applications for Medical Assistance for the Aged are accepted and cleared prior to the need for medical care wherever possible. Emergency clearance procedures are being set up to handle critical cases. The State Board of Health is responsible for the standards of institutions, including those which provide Medical Assistance for the Aged.

ELIGIBILITY REQUIREMENTS

Age—65 and over.

Residence—The applicant must be a resident of the state—or if temporarily living out of state, must have established legal residence in S. C.

Lien—No lien or encumbrance may be placed against the property of an applicant, either prior to or after his death, because of medical assistance for the aged paid on his behalf.

No enrollment fees or charges required as condition of eligibility.

NEED REQUIREMENTS:*

Single — Annual income not exceeding $1,000.00
Savings of $500.00

Couple — Annual income not exceeding $1,800.00
Savings of $800.00

A person's homestead is exempt

Personal Property is exempt.

*(See full report for further explanation Need Requirement).

REDETERMINATION

Redetermination of eligibility will be made annually, for each person who has been determined eligible for Medical Assistance to the Aged.

SCOPE OF MEDICAL SERVICES HOSPITALIZATION:

General hospital care will be provided for an individual who has been certified by the county welfare department as meeting the need and other eligibility requirements, and who has been certified by a physician as acutely ill, injured or has sight-endangering condition making hospitalization essential for treatment. Eight days of care will be county health department's initial authorization. Extended authorization—up to 40 days—may be made by physician.

NURSING CARE:

On the recommendation of attending physician, nursing care will be provided up to a period of three months, except in extreme cases requiring longer periods. Nursing period may be extended upon written approval of State Health Department.

NON-INSTITUTIONAL MEDICAL CARE:

Emergency Room Service _____$4.00 per visit
(To include drugs administered in emergency room, oxygen, small casts, sutures, dressings, etc.)

Organized Clinic Service _____$3.00 per visit
(To include drugs administered in the clinic, oxygen, dressings, cast removal, etc.)

Special Diagnostic and Therapeutic Services
(On request of physician)

Laboratory Procedures	$ 2.50
X-Ray & Radioisotope Procedures	$ 6.00
Intravenous Solutions	$ 2.50
Electrocardiograms	$ 5.00
Minor Surgery	$10.00

Persons under Medical Assistance are eligible for three visits during a 31-day period to a hospital or clinic for out-patient services.

FOOTNOTE:

At the end of the first year of Kerr-Mills aid in South Carolina, more than 4000 persons had received Medical Assistance for the Aged. The total expenditure during the first year was $750,000.00.

If the members of your county society are not familiar with Kerr-Mills it is suggested that the next regular meeting might be given to a discussion of the implementation of this law in South Carolina.

News

Symposium on Comparative Medicine

The first International Symposium on Comparative Medicine will be held at the Waldorf-Astoria Hotel and The Animal Medical Center in New York City October 10-12. Supported by a grant from Eaton Laboratories Division of the Norwich Pharmacal Company, Norwich, N. Y., the program will include 44 participants from the U. S. and five foreign countries. Physicians and veterinarians are invited to attend.

J. Earle Furman, M. D. and John E. Zeliff, M. D. announce the association of Jack W. Chandler, Jr., M. D. in the practice of Pediatrics at 301 Anderson Street, Greenville.

Film on Child Health

"Journey in Health," a 16mm sound film on the continuous health supervision of children, produced by the Smart Family Foundatiin in cooperation with the American Medical Association and the American Academy of Pediatrics, is now available to professional organizations, institutions, and medical personnel as part of the Smart Family Foundation public service program to improve medical care. The film may be rented from AMA or the American Hospital Association or purchased at below cost price from the Smart Family Foundation, 65 East South Water St., Chicago 1, Ill.

Hospital Costs Rise

American hospitals cared for nearly half a million more patients and cost nearly 1 billion dollars more to operate in 1961 than in 1960, it is reported by the American Hospital Association. The increase in cost ($9,387,242,000 over $8,420,986,000) is attributed both to rising payrolls and to an average increase of $2.75 per patient day in the nonfederal short-term general hospitals.

New Booklet Available

Complimentary copies of a new booklet, "Your Physician Looks at Health and Productivity," published by the American College of Physicians, are available for limited distribution from the College headquarters, 4200 Pine Street, Philadelphia 4, Pa. The material presented in the booklet has been adapted from a Public Information Forum on Health and Productivity presented under the auspices of the American College of Physicians and the Chamber of Commerce of Greater Philadelphia.

Army Supports Grant at Medical College

Dr. H. R. Pratt-Thomas, President of the Medical College of South Carolina has announced that a research grant has been received by the Department of Surgery from the U. S. Army, Research Development Command, naming Dr. George H. A. Clowes, Jr., Chairman of the Department, as principal investigator.

Title of the grant is "The Cardiac Output and Vascular Response of Trauma" and it is in the amount of $38,000 per year. This is a continuation grant, and is the second year of the study which previously has been carried on at Western Reserve University in Cleveland under Dr. Clowes' direction.

St. Francis Hospital Greenville, Plans Expansion

"The Good Sister of Vardry Heights"—St. Francis Hospital—is nearing the 30th anniversary of its service to Greenville with plans in the making for potentially greater service.

A 14.6-acre tract at the rear and immediately adjacent to the present building already has been acquired as the site of a proposed new hospital.

The original announcement said it would have 250 beds, but present plans call for a smaller beginning, perhaps 125, with finances to be the deciding factor.

The existing building, which has a capacity of 97 beds, will then be used as a nursing home for care of the aged and chronically ill.

Marion Doctor Warns Against Socialism

Dr. Ira Barth, Marion physician, lashed out against socialized medicine as he spoke to the Marion Rotary Club at their weekly luncheon meeting.

The doctor concluded his address by saying, "Although the Medicare Bill has been defeated it will probably be brought up again. We should all write to our senators and congressmen and let them know we are against it."

Georgetown

The need for establishing a municipal board of health was discussed at a special meeting of the Georgetown City Council with the city attorney and various department heads recently.

J. T. Taylor, M. D. announces the opening of his office for the practice of General Medicine in Ridgeville, S. C.

Postgraduate Course in Ophthalmology

The Fourth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine will be presented on November 29 and 30, 1962, at the Grady Memorial Hospital, Atlanta, under the sponsorship of the Department of Ophthalmology, Emory University School of Medicine.

Ocular therapy is to be featured. As in the past, the course is designed for the practicing clinical ophthalmologist and will consist of lectures and panel discussions by outstanding national authorities on the medical therapy of many of the ocular conditions commonly encountered in everyday practice. Certain minor surgical procedures are to be included.

The guest lecturers for the 1962 course will be Dr. James H. Allen, Tulane University School of Medicine; Dr. Gordon Bruce, College of Physicians and Surgeons, Columbia University, and Dr. John McGavic, Temple University School of Medicine.

Residency Plan Instituted at State Hospital

A three-year residency program in psychiatric training has been approved for South Carolina's State Hospital in Columbia, Dr. William S. Hall, Superintendent, has announced.

The training program was approved in April by the Residency Review Committee for Psychiatry and Neurology, representing the American Board of Psychiatry and Neurology and the American Medical Association. Official notice of the decision was recently received by Dr. Hall.

The psychiatric training program is designed to meet the Palmetto State's urgent need for additional psychiatrists with broad training and experience in this specialty.

South Carolina's only other approved psychiatric residency training program is at the Medical College Hospital in Charleston. In the United States, there are only fifty approved programs of this type in State Hospitals.

Blood Plan Endorsed By Greenville Medical Society

Members of the Greenville County Medical Society have endorsed a plan through which persons who participate may obtain needed blood without too much cost.

The proposal which requires an annual membership fee of $10 per family or donation of one pint of blood, received the approval of the medical members and also their agreement to share the financing of the program to get it under way.

Dr. Arthur Dreskin, who has served for the past year as chairman of the investigating committee, presented the plan to the board. It has worked successfully in other cities.

The primary purpose of the program is to provide blood when necessary, the receiver, if a member of the plan, being relieved of burdensome bills. Blood will be provided to members without cost.

Dr. W. E. Dukes, New In Clemson

Dr. William E. Dukes joined the office of Dr. Robert H. Burley in Clemson on July 1.

Dr. Dukes 32, will practice general medicine and surgery.

Dr. Dukes graduated from Clemson College in 1957 and finished the Medical College of South Carolina in 1961.

Dr. Sowell Establishes Practice

Dr. Broadus Sowell will set up private practice in Pageland at the old Ray Yandle home site.

Originally from Chesterfield, he studied in Charleston, then moved to Florence and served his internship at McLeod Infirmary.

He moved to Chesterfield for a period of 19 months where he practiced medicine with Dr. W. R. Wylie, Sr.

Dr. Horger

DR. EDGAR OLIN HORGER, III is a FOURTH generation graduate of the Medical College of South Carolina, a fact in which the institution takes as great pride as do his family and friends.

The '62 graduate is the son of Mrs. E. O. Horger, Jr. of Phillips Lane and the late Dr. Horger, who came to Greenville in 1938 as a resident at St. Francis Hospital, and died here in 1951.

The young Greenvillian, his father, his grandfather, the first Dr. E. O. Horger, and his great-grandfather, Dr. A. I. Horger, are all graduates of the Medical College of South Carolina.

But there is more! His maternal great grandfather, Dr. A. H. Bowen; an uncle, Dr. R. C. Horger of Orangeburg and a great uncle, Dr. A. A. Horger, are all alumni of the institution where the family name is held in high esteem.

There is also the possibility of still another Horger for the Medical College. The youngest doctor by that name and his most attractive wife, the former Polly Jo Collins of Mullins, agreed on a recent visit here that their young son, E. O. Horger, IV, doesn't have much choice in this matter of a profession and where he is to pursue his education, if family tradition means anything at all.

The visitors have now returned to Charleston where young Dr. Horger will begin his internship at the Medical College hospital.

New Addition For Florence Hospital

McLeod Infirmary will probably have a new addition to the records department and a modern central dictation system in operation this fall, said administrator Kenneth Gallier.

Dream Realized for Dr. Walter Mead

Opening of Palmetto Center, a state-operated alcoholics rehabilitation facility, is the fufilment of a dream, among others, of Dr. Walter R. Mead of Florence.

As chairman of the State Alcoholic Rehabilitation Board, Dr. Mead has been diligent in pursuit of this physical facility for the treatment of alcoholics. At the same time, even in the absence of this facility,

he has given much of his time to the treatment of alcoholics.

He long ago recognized alcoholism as a disease requiring the same kind of skilled care and treatment as other diseases, and with that fact known to him, he has been a principal pioneer in its treatment.

Now with a staff and physical facility available, embracing the latest known techniques in treating alcoholism, the area of his service is greatly expanded. It is a great new tool placed in the hands of a man and his associates who have already been using to good advantage the tools available.

Dr. Francis To Open Office In Pickens Area

Dr. William W. Francis of Blacksburg, has opened an office for general practice of medicine in Pickens, July 20.

Dr. Francis received medical training at Bowman-Gray School of Medicine and has just completed a year's internship at the General Hospital in Greenville.

He will be associated with Dr. J. M. Hardin and Dr. D. Mauldin in Pickens.

Bethune Doctor Resident At Medical College

Dr. Raymond E. Ackerman has accepted a three year residency in psychiatry at the Medical College Hospital and will begin his duties July 1.

Dr. Ackerman is a graduate of Clemson College, class of 1949, and the Medical College of South Carolina, class of 1954. He interned at the U. S. Naval Hospital and served two years in the U. S. Navy at the Charleston Navy Yard.

Dr. Ackerman has been practicing medicine at Bethune for five years.

Aiken Hospital Staff

The following Aiken physicians have recently been elected as officers of the staff of the Aiken County Hospital: Chief of Staff, Dr. J. E. Rountree; Vice-Chief of Staff, Dr. Wallace D. McNair, Jr.; secretary, Dr. James E. Padgett, Jr.

Dr. Rountree succeeds Dr. F. A. Kennedy as Chief of Staff.

Dr. J. E. Padgett, Jr., Certified Pediatrician

Dr. James E. (Jack) Padgett, Jr., Aiken pediatrician, has recently been certified by the American Board of Pediatrics. The certification is awarded after the candidate has successfully completed written and oral examinations covering the field of pediatrics. He is now eligible to be a member of the American Academy of Pediatrics.

A.A.G.P. Schedules Scientific Assembly

The Annual Scientific Assembly of the South Carolina Chapter of A.A.G.P. will be held in Charleston at the Francis Marion Hotel, September 27, 28. The program will be presented entirely by outstanding graduates of the Medical College of South Carolina, at least four of whom are returning to Charleston from other states especially to participate in the Assembly.

American Cancer Society

The 1962 Scientific Session of the American Cancer Society will be held at the Biltmore Hotel, New York City, October 22-23, 1962. The theme, "The Clinical Impact of a Quarter Century of Cancer Research," will celebrate Cancer Progress Year—1962 being the 25th anniversary of the National Cancer Institute. For further information write: Director of Professional Education, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

Southern Medical Association

The 56th Annual Meeting of the Southern Medical Association will take place in Miami Beach, Fla., November 12-15. There will be 21 scientific sections, all held at the Fontainebleau Hotel which will house both the meeting rooms and the scientific and technical exhibits.

Charlotte Postgraduate Seminar

The Charlotte Postgraduate Seminar, scheduled for October 10, 11, will feature this year nearly a dozen speakers from various parts of the country. The list includes: Drs. Julian R. Beckwith, Stuart S. Stevenson, Isadore Dyer, Sol Katz, Edward Orgain, Cheves Smythe, Arnold P. Friedman, Glenn W. Irwin, Colin Thomas and Robert B. Greenblatt. The banquet speaker will be Dr. Edward R. Annis, President Elect of the American Medical Association.

New Seal Commemorates State Hospital Service

Affixed to every letter mailed from the South Carolina State Hospital this year is a large gold and maroon seal commemorating the 135 years of service in South Carolina for the mentally ill since the original unit of the S. C. State Hospital, the Mills Building, was completed and ready for patients December 18, 1827.

The act of the South Carolina General Assembly establishing and authorizing the construction of a building for the care and treatment of the mentally ill was December, 1821.

The cornerstone of this building was laid July 22, 1822, and the structure named the Mills Building in honor of the designer, the South Carolina architect, Robert Mills of Charleston.

Although completed and ready for patients December 18, 1827, the first patient, a young white woman from Barnwell County, was not admitted to the Mills Building until December 12, 1828.

The South Carolina State Hospital was the second

such institution in the United States to be established but was the third to be ready for patients. The first state hospital for the mentally ill was opened in Williamsburg, Va., October 12, 1773, and the second was the Eastern State Hospital in Lexington, Ky., May 1, 1824. The S. C. State Hospital was the third December 18, 1827.

Dr. William S. Hall, superintendent of the State Hospital, said the patient population at this time is 6,687; and the hospital consists of two separate units, one in the city, the Columbia unit, for white patients, and the other on Highway 555 about six and a half miles from Columbia, the State Park unit, for Negro patients.

Dr. Martin To Practice In Columbia

J. Frank Martin, M. D., has announced opening for general practice his office at 1214 Bull Street.

Doctor Martin took his pre-medical training at the Citadel and the College of Charleston. He was graduated from the Medical College of South Carolina in June, 1961 and interned at the Columbia Hospital.

Doctor Martin, who was employed by the Savannah River plant of E. I. DuPont de Nemours & Co. for three years, is a veteran of the U. S. Army.

Senator Morris Cited For Work In Mental Health Field

Pickens County's Senator Earle E. Morris, Jr. was honored recently "in recognition of his sincere and dedicated efforts in behalf of the mentally retarded" in the State.

Morris is chairman of a special Legislative Committee on Mental Health and Mental Institutions, and has headed that group's program to upgrade the mental health programs in the State.

Recognition for his efforts came from the South Carolina Association for Retarded Children, which presented him with a plaque.

Dr. O. B. Mayer At Meeting

Dr. O. B. Mayer, Columbia physician recently attended a meeting of the Surgeon General's advisory committee on accident prevention, of which he is a member.

Dr. Stands Elected Red Cross Chairman

Dr. Benjamin O. Stands has been elected chairman of the Richland County Chapter, American Red Cross. He will serve as chairman for one year.

Dr. White Joins Public Health Service of Maryland

Dr. Benjamin D. White, recently assistant superintendent of the South Carolina State Training School for Mentally Retarded at Clinton, has joined the State Department of Health of Maryland as full-time director of a state-wide program of local health services for the mentally retarded.

Myrtle Beach Gets Board of Health

A city Board of Health has been established by the Myrtle Beach City Council. There will be a six man board and Dr. G. P. Joseph will serve as city health officer.

Dr. Humphries Has Retired

Dr. A. W. Humphries, Kershaw County Health officer for the past 33 years has entered compulsory retirement.

Dr. Humphries is a member of the State Retirement System, and under the provisions of Section 61-103 of the State Code, he must be retired upon reaching the age of 72. Dr. Humphries was 72 last September.

Dr. Julian Hard, who has established an office for private practice in Bethune, has been employed as part-time Kershaw County Health Officer, (to be called a clinician), and will work in this capacity until such time as the reactivated Kershaw County Board of Health makes other arrangements.

Dr. Humphries will be retained in the capacity of a consultant for the next fiscal year.

Under Dr. Humphries' direction, the Kershaw County Health Department became one of the most efficient in the state. He is one of the very few health directors in South Carolina who is a member of the general hospital medical staff.

Radiologist Joins Hospital Staff

The Hampton General Hospital has added a radiologist to the staff. Dr. Ronald Glover of Beaufort will be visiting radiologist four days per week for the Hampton General Hospital.

He will also serve the Allendale County, Barnwell County and Beaufort County Hospitals.

He is a lieutenant commander at the U. S. Naval Hospital, Beaufort, on terminal leave, shortly to be out of service.

A Princeton University graduate, he received his M.D. at Columbia University School of Medicine and completed his work in radiology there also. He has been in Naval service since then. He is a member of the American Medical Society, the Radiology Society of North America, a member of the American College of Radiologists and is certified by the American Board of Radiologists. He also is a member of the S. C. Radiographic Society.

Dr. Jackson To Practice In Manning

Robert E. Jackson, M.D., has opened an office in Manning for the general practice of medicine.

Dr. Jackson, 26, is a graduate of the Medical College of S. C. He recently completed a year's internship at the Medical College Hospital.

Two Doctors Open Offices In Anderson

DR. KARL V. GREGG, a native of Florence, has opened offices in the Mutual Building, 1221 North Fant Street, Anderson. Dr. Gregg will practice obstetrics and gynecology.

DR. WARREN WHITE, a general practitioner, has opened offices at 1501 North Main Street, Anderson.

A native of Cochran, Ga., Dr. White came to Anderson from Jasper, Ala., where he was located two years.

He graduated from the Medical College of Georgia at Augusta before serving his internship at University Hospital at Birmingham, Ala. He also spent a year of practice residency at Lallie Kemp Charity Hospital, Independence, La.

Anderson County Delegation Considers Nursing School

The construction of a $1,500,000 school of Nursing at Anderson Memorial Hospital, with two-thirds of the cost coming from Hill-Burton funds, is being considered by the Anderson County Delegation. The deadline for accepting or turning down the federal allocation to Anderson County for the nursing school which would have facilities for training 180 nurses is tentatively set for early September.

Films Available

Three 16 mm sound films on Management of Mass Casualties (1) sorting; (2) mechanical injuries; (3) burns, are now available from the Local Defense Director and the films are obtainable from the Third Army Film Library, Federal Court House, Columbia, S. C., Atten.: Mr. R. E. Arrowood. Another film, Crash Research, may be ordered from the State Highway Department, Safety Division, Columbia, S. C.

Clay W. Evatt, M. D., Ophthalmology and Otolaryngology, announces the association of Clay W. Evatt, Jr., M. D., Ophthalmology, 91 Rutledge Avenue, Charleston.

F. Raymond Price, Jr., M. D. announces the opening of his office at 96 Rutledge Avenue, Charleston, South Carolina, for the practice of Urology.

Congress on Mental Illness and Health

The American Medical Association will hold its first National Congress on Mental Illness and Health in Chicago, October 4-6. The purpose of the Congress, held with the cooperation of the American Psychiatric Association and the support of the National Association for Mental Health, is to plan specific activities to implement the new mental health program developed by the AMA's Council on Mental Health.

Participants will meet in both topical and regional discussion groups to develop coordinated and continuing mental health programs to be carried out at the national, state and local levels. The AMA hopes that as many physicians and interested citizens as possible will take part in the Congress. More detailed information on the Congress itself and copies of the AMA mental health program can be obtained from the Council on Mental Health, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

Medical Secretaries

Greenville General Hospital moved a step further along the road to Southeastern regional leadership when it graduated its first class of medical secretaries.

No more than a dozen hospitals in the United States give such training. General possibly is the only Southeastern hospital with the course.

The hospital has grown great in recent years—not only in size but in stature. It now attracts the best medical talent. Greenville has every reason to believe that soon General will rank with the top hospitals of the United States.

Charles P. Darby, Jr., M. D. announces the opening of his office on Highway 17, Mount Pleasant, S. C. for the practice of Pediatrics.

Dr. Aimar In Nationwide Test

From a portable location in a cornfield near the Mont Clare Road, Dr. Charles E. Aimar participated in a 24-hour nationwide test of emergency communication facilities by amateur radio operators throughout the U. S.

Called "Field Day," the test was to exercise the ability of individual stations to operate at a portable location using emergency power.

Dr. Aimar, a "ham" operator since 1959, operates Amateur Radio Station K4ZVQ in Darlington. Through his station Dr. Aimar contacted 50 stations, mostly in South and North Carolina, using a 50-watt transmitter powered by a portable generator.

Greenwood Gets New Physician

Dr. E. Mims Mobley, Jr. is a new physician in Greenwood. He is associated with Dr. Wiley N. Price and will specialize in internal medicine.

Dr. Mobley, a native of Edgefield, graduated from The Citadel in 1951 and the Medical College of South Carolina in 1955.

Dr. Mobley served his internship at the Medical College Hospital and then was an assistant resident there. He was a medical officer in the Navy 1957-59, stationed in Texas, and was later in private practice in Houston, Texas.

He returned to the Medical College in Charleston last year as a teaching fellow in internal medicine and for the last six months has done research in cardiovascular diseases.

Medical College of Georgia

The Medical College of Georgia's Department of Continuing Education has planned a series of five intensive postgraduate courses for the fall and winter 1962-63.

The courses planned are:

"Clinical Pathology in Medical Practice"
October 23-25, 1962
"Diagnosis and Practical Management of Arthritis"
November 13-15, 1962
"Orthopedics in General Practice"
December 4-6, 1962

"Growth and Development—Management of Common Behavior Disturbances"
February 12-14, 1963
"Gynecologic Problems in Private Practice"
March 12-14, 1963

Invited faculty will include nationally known figures as: William J. Cromartie, M. D., Univ. of North Carolina; Paul Heller, M. D., Director of Research, Univ. of Illinois College of Medicine; Elam C. Toone, Jr., M. D., Medical College of Virginia; F. James Funk, Jr., M. D., Emory Univ. School of Medicine; C. Roger Sullivan, M. D., Mayo Clinic and Mayo Foundation; Albert J. Solnit, M. D., Yale Univ.; and Simon V. Ward, M. D., Louisiana State Univ. School of Medicine. Faculty members of the Medical College of Georgia will participate.

Each course is acceptable for 18 hours credit by the American Academy of General Practice. Registration is limited to a small group for close participant-faculty communication. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

Promotions and Appointments of Clinical Faculty Medical College of South Carolina

PROMOTIONS

Henry Baker Gregorie, M. D., from Instructor to Associate in Surgery.

William Clyde Miller, Jr., M. D., from Instructor to Associate in Psychiatry.

George Henry Orvin, M. D., from Instructor to Associate in Psychiatry.

Raymond Rosenblum, M. D., from Instructor to Clinical Associate in Urology.

Julian Thomas Buxton, Jr., M. D., from Teaching Fellow in Surgery to Instructor in Surgery.

NEW APPOINTMENTS

Hubert Oliver Williamson, M. D., Associate in Obstetrics and Gynecology.

William Steve Lang, Jr., M. D., Associate in Otolaryngology.

Eugene Francis McManus, M. D., Clinical Instructor in Pediatrics.

William Bruce Newton, M. D., Clinical Instructor in Psychiatry.

Francis Raymond Price, Jr., M. D., Clinical Instructor in Urology.

Charles Pickney Darby, Jr., M. D., Clinical Assistant in Pediatrics.

Clay Welborn Evatt, Jr., M. D., Clinical Assistant in Opthalmology.

Carlisle Hewitt, M. D., Clinical Assistant in Radiology.

Robert Polk Linker, M. D., Clinical Assistant in Anesthesiology.

Margaret Hunter McCarthy, M. D., Clinical Assistant in Anesthesiology.

Miller Nathaniel Richbourg, M. D., Clinical Assistant in Anesthesiology.

Betty Jean Wood, M. D., Clinical Assistant in Opthalmology.

Correspondence

August 7, 1962

Dear Dr. Waring:

Your editorial in the July issue of the South Carolina Medical Journal in regards to additional medical educational facilities in our state, was read with a great deal of interest. It was gratifying to have expressed in our Journal the recognized opinion that more physicians are needed, as the supply has not kept up with our budgering population. However, certain thoughts expressed in the editorial could be more thoroughly studied and the facts brought to the attention of the members of the society.

The problem is a very acute one, particularly in South Carolina. The national average in the United States is 1.38 physicians per 1,000 population, while the Southeastern average is 1.11 per 1,000. South Carolina's physician ratio is 0.73 per 1,000. Of the 1,781 physicians in the state of South Carolina in active practice (and of these, unfortunately, only 1,402 are members of the Medical Association) only 866 are graduates of the medical school of the state of South Carolina. No figures are kept nor any that we can find available for the percentage that rereived their post-graduate education outside of the state, but the percentage who received this part of their education out of the state is undoubtedly far greater. In addition, there are forty-eight retired members of the society, twenty-three of whom were graduated from the Medical College. (This information is supplied by a letter from Mr. M. L. Meadors, July 5, 1962.)

This editorial, which discusses such a critical situation and which can only be solved by supplying as much information as possible to every member of all groups, was written with very little information obtained or at least presented. The matter of a school of basic medical sciences in Columbia associated with the University of South Carolina arose not with the Chamber of Commerce as implied, but with the local medical society. A committee has been working in the years 1960, 1961, and 1962, diligently looking into the problem from every possible fact that we could obtain. You will note on page 231 in the same issue of the Journal in the minutes of the Council meeting of the South Carolina Medical Association a group of three members of the Council were asked to attend the meeting. These gentlemen and others were not only "proposed" to attend by Council, but also received invitations from the group here in Columbia and not one of them was present at the meet-

ing of May 16, nor again at the meeting of July 19. Nor, was the editor of the South Carolina Medical Journal present. These meetings were stressed to be purely for obtaining as much information as possible and to explain our aims and the work being done. However, we did have Dr. Tom Pitts, President of the Board of Trustees of the Medical College of South Carolina who graciously accepted. Dr. Pitts was present to listen to any information as related to the overall medical education in the state.

There were two other points brought out in your editorial, the first having to do with the statement in your article which reads. "One may wonder whether physicians of the areas now talking medical schools are desirous of themselves participating in a teaching program, or would be content with importation of a new and fulltime faculty." I know of no one on our committee or our society who feels that they are doing this study to be on the staff of the teaching facility, and all feel and have been so advised that a completely new and excellently trained fulltime faculty will and can be obtained. As a result, we would like to point out that this is not a matter of personal selfishness or any sectionalism as suggested in the editorial, but simply that it is our responsibility as physicians practicing in the state to provide more physicians, not only as needed now but will be more acutely needed as the population grows and will become more serious.

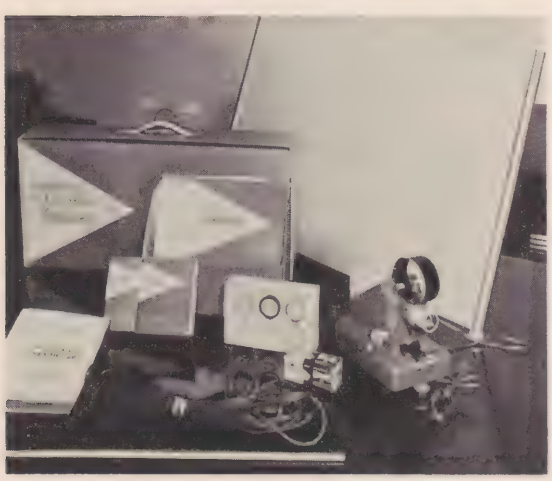
The point concerning the financial support of the school in Charleston is certainly one that should be and is being considered. Our committee from the Medical Society and also the Chamber of Commerce here is making every effort to look into the finances of the school not only in our state, but also state supported schools in North Carolina, Georgia, Florida, and Virginia, so that we can get a complete picture of what is needed. It would be ridiculous to try to provide the people of South Carolina with better medical personnel and facilities at the expense of the present school. There is a great need for each and every physician of the state to be fully informed, and it is his or her duty to work to provide medical benefits for the people of the state. The only way this can be done is by a complete study and effort on the part of everyone in the state including the officers of our society and the editor of the Journal. After the information is obtained, then it should be presented completely, unbiasedly and the best solution worked out.

I assure you that if at any time we can supply you with any information that we have obtained, or if you would like to have anyone of our committee members come down and talk to you or any group that might be interested, we will be glad to do so. Our committee has tried to cooperate with everyone at every level in our search for all facts needed and will continue to do so. Again, may we state that the cooperation of each and every member of our society and of others who are interested in medical education care for the people of South Carolina is necessary to the highest possible extent.

Sincerely,
John R. Harvin, M. D.
Chairman of the Committee
on Medical Education of the
Columbia Medical Society

Editors Note: This is the first official communication that has come to the Journal, which is always eager to have information but all too seldom receives it except through the newspapers. The editor cannot recall any invitation to attend the meetings mentioned, but perhaps his memory is at fault.

Civil Defense



South Carolina has climbed to a second place nationwide ranking in a new field—Medical Self Help Training.

Walter C. Hughes, Regional Health Mobilization Director of the Public Health Service, Atlanta, Ga., termed the accomplishment as "extremely impressive." He informed Dr. G. S. T. Peeples, State Health Officer, that the number of courses completed in South Carolina represents approximately one-seventh the total completed in the nation.

MSH is a common effort of the S. C. Civil Defense Agency and the State Board of Health.

Described as the largest single medical training program for individuals ever undertaken in South Carolina, MSH is designed to train citizens in the fundamentals of health care—especially under disaster conditions. The value of the training in day-to-day living can't be overlooked. But the principal objective of the program is to educate members of every

family in our nation in basic health procedures needed to sustain life during critical periods.

Devised by the Public Health Service of the Department of Health, Education and Welfare and the Office of Civil Defense, the training program is divided into 12 lessons, usually taught in eight-two-hour sessions. The instruction covers such subjects as fallout and shelter, shock, bleeding and bandaging, and for adult classes even emergency childbirth.

To implement the instruction, a unique training kit (shown in photo above) was developed. Weighing only 20 pounds, the kit contains such training aids as color filmstrips, projector and screen, instructor's guide and student handbooks. Initially, only a limited number of these kits have been available. But the 1963 fiscal year budget of the Public Health Service includes a request for funds to obtain 25,000 additional training kits.

The first objective of the MSH program in South Carolina was to train one member of 1500 families throughout the state. In less than four months this objective has almost been reached, for already over 1100 have completed this new and vital educational program—a tribute to the government agencies and individuals working on the project.

THE DISCOURAGED SPEAKER

By Henry Heins, M. D.

As a member of Charleston County Medical Society's Speakers Bureau, I have been "making the rounds" of service clubs speaking on "Medical Care of the Aged."

It has been postulated that this type endeavor is somewhat like the minister preaching against sin and his congregation nodding in complete agreement. We thought we were spreading information about the subject but not really changing any minds since most of these clubs are made up of conservative type individuals.

What was needed, we thought, was to reach the other group of individuals, those of liberal bent—the unions!

It was arranged that I should address the Greater Charleston Labor Council, a group of delegates of the various local unions about the area. I met with these "captains of labor" in one of their clubs—The Tobacco Workers Union Hall. I should correctly say we were supposed to meet there, but the union official who was supposed to open the hall was soundly sleeping or comatose of some other etiology and could not be aroused to let us into the meeting place. Rather than hold the meeting in the street, we proceeded in caravan fashion to County Hall to have our get-together.

I must say these people were polite while I was speaking. There were only a few snickers and shy grins as I defended Kerr-Mills and assailed King-Anderson. These looks did not bother me near as much as the signs on the walls—"Our Leader is Dead" by a large picture of Mr. Franklin Roosevelt and "So Follow the New Frontier" and a picture of President Kennedy. There were other pictures of Sen. Olin Johnson—"The Friend of the Working Man." Many other signs extolled the age and values of the Labor Movement.

The second mistake I made (the first one is obvious—that of going to the meeting) was to ask for questions at the end of my talk. Several members jumped to their feet, waving copies of the King-Anderson bill. These people are not interested in our side of the argument. Their minds are made up and they do not want to be confused with the facts.

These union officials were offended when I suggested they were letting the government assume their personal responsibilities. They felt they were paying their own way with Social Security taxes.

I am pleased that King-Anderson is checked for at least one year. This is just a respite. I am sure the New Frontier will push it hard next year. When I think of those stolid union officials in County Hall, I become very morose. I am afraid if they outnumber us, and I believe they do, we are going to have some type of government medicine.

At any rate, I will confine my speaking to service clubs in the future (that bullet proof vest is too uncomfortable).

SERVICE FOR TOMORROW: DEVELOPMENT PLAN OF THE MEDICAL COLLEGE OF SOUTH CAROLINA

H. R. Pratt-Thomas, M. D.

In projecting and planning for the development of the Medical College of South Carolina during the next decade, I would like to present for your consideration and information the SERVICE FOR TOMORROW Development Plan of the Medical College of South Carolina. It is imperative that the Medical College, South Carolina's major educational center devoted to the teaching and training of students and graduates in the health sciences, devise a program of progress and expansion which will guarantee the best possible medical care for the citizens of South Carolina.

If I may digress momentarily, I would like to make some general observations concerning plans and decisions.

Having had the opportunity to contrast the differences in various disciplines, I am now in a position to make comparisons. As a pathologist I was generally able to render a diagnosis with the related prognostic implications, within a few moments or at least in the course of an afternoon. As an educational executive I often look at the problems of medical education and am able to generate only a "delayed conjecture". Although stimulating this is also a most exasperating experience. To wait out long range plans, rather than taking immediate definitive action—to fiddle and burn simultaneously is much worse than total inertia. Some of the problems appear to have no immediate solutions, simply temporary adjustments or expedient improvisations. Frustrating dilemmas persist and multiply. Problems flourish in the hours of darkness like the night-blooming Cereus; mocking questions rise and stand as immutable as the Berlin Wall. Some problems refuse to be "figured out" of existence either because of their complexity or because their resolution will create others of equal or even greater magnitude. It has been revealing to discover that the problems of administration are in large part fiscal—as one of my colleagues remarked the other day, "It would be refreshing to discuss something that did not involve money". Perhaps it is a commentary on our present way of life to observe that policies, plans, and even ideals are frequently modified if not actually manipulated by fiscal considerations. The problem of recruitment of high class applicants to study medicine is in part related to the cost of medical education; the procurement of an outstanding faculty is related to the salary that you are able to pay and the facilities that the school is able to furnish; the renovation and construction of new medical teaching facilities are related to per capita income and the division of the tax dollar; per diem rates of hospital care have to be constantly adjusted to meet the cost of food, supplies, and wage demands of ancilliary personnel.

The Service for Tomorrow Development Program is as follows:

Primary Goal

To furnish the citizens of South Carolina with the best possible health care.

Fundamental Objectives

1. To accept for educational guidance, intellectually qualified and emotionally balanced young men and women with the proper scientific, cultural and social orientation.
2. To perfuse these students with the sound basic principles of medicine so as to enable them as graduates to proceed with their training for practice, teaching, research, or all three.
3. To promote and expand the other branches of the health profession such as nursing, pharmacy, medical technology and other paramedical services so as to insure a continuing and adequate supply of such vital personnel.
4. Expansion of the continuation education programs in medicine, nursing and pharmacy.
5. Development of recruitment programs for potential physicians, dentists and nurses at the high school level.
6. To foster growth of the graduate study program in the basic medical sciences.
7. Plan and work with the State and local community hospitals and health programs in order to assure co-ordination and support for the educational objectives of the Medical College so that advances in health care can be cooperatively achieved.

Requirements to Meet Major Goal and Fundamental Objectives

1. To provide those physical facilities which are practical, sufficiently modern and cohesive in design as to furnish an academic environment which is adequate and acceptable.

   ESSENTIALS:

   A NEW LIBRARY.

   CONSTRUCTION AND RENOVATION OF BASIC SCIENCE FACILITIES.
2. Construction of a dental school with facilities and faculty to provide for classes of 50.
3. Expansion of classes in medicine by 25%.
4. Expansion of classes in nursing by 55%.
5. Procure and retain a faculty of sufficient strength, stature and excellence to provide not only the mechanics of instruction but with the important capability of imparting a stimulus and desire to apply this knowledge effectively.

Address of the President of the Medical College of South Carolina to the Annual Meeting of the Alumni Association, May, 1962.

"There can be no compromise with excellence!"

It is not possible to discuss each point in detail and we will survey the implications of only some of these proposals. It is mandatory that the Medical College of South Carolina make extensive study and analysis of its requirements and objectives as pertains to its physical facilities, faculty requirements and curriculum design. This study should have as its objective to increase the present medical school classes from 80 to at least 100; to expand classes in nursing; and to establish a dental school. Having a fine teaching hospital and research building, our attention should now be directed to the basic science building—a common designation for a facility used entirely for instruction in the first two years of medicine, although instruction is no longer limited in the first two years to these basic disciplines and must provide for a proper introduction into the clinical sciences.

Although the entering class of the School of Medicine contains 80 students, the total amount of present space, including the new research building area, is almost 30% less than the standards required. Furthermore, as much as 30% of the present space, or 50,000 net square feet is in poor condition and should probably be replaced. Those medical and basic science facilities constructed elsewhere since 1955 have varied in cost from $2,900,000 to $14,000,000.[1] They accommodate classes of 50 to 150 students. The cost of construction per entering freshman is calculated to be slightly in excess of $70,000.

Darthmouth College occupied a new medical science building in 1960. This current experience is particularly revealing and helpful to those who are charged with construction of similar facilities. It was planned for classes of 50 medical students and contained the teaching and research facilities for the basic medical science (preclinical) departments. The cost of the building was $3,500,000. Additional library and auditorium needs were estimated to be $1,000,000. Dartmouth's medical science building has approximately 81,000 square feet of floor space and the cost per square foot was about $43.00, movable equipment being included in this figure.

Harrell[2] with his experience in the construction of a new medical school at the University of Florida states "at least $30.00 per square foot should be planned for construction and fixed equipment".

Library construction costs are apt to be somewhat less,[3] running from between $15 to $20 per square foot, including equipment. A library of the recommended size for our present and projected growth should supply from 23,000 to 25,000 square feet.[4]

Some of our buildings date to 1913 and are not only inadequate for the projections of the future but entail maintenance costs which are no longer sound and reasonable. Furthermore, an excellent medical library is essential to a first rate medical school. It is the life and blood and intellectual core of any educational institution, as it is the repository for the accumulation of scientific information which it makes available to students of the health profession and the professional members of the health team. Our present library was built in 1930 and at that time was a focal point within the Medical College area. The closing of Old Roper, the construction of the Medical College Hospital, and now the Research Building have turned the tides of traffic. It is being by-passed. Furthermore, it was built when the Medical College classes were limited to 40 and there were very few house staff members and very few full time instructors. Volumes and periodicals have steadily increased necessitating the construction of new stacks which have further encroached on the study and reading areas. Now that the student body of the School of Medicine has doubled and 80 full time faculty members are employed, with a house staff of more than 100, more graduate students and an explosion in research activity, the need for a new library has now reached the point of dire necessity. Medical library collections tend to double in about twenty years. New libraries should provide space for growth to at least 100,000 volumes and 1,000 journal subscriptions. Medical schools with extensive research programs especially need expanded library resources. The increase in size of medical student classes, an expansion of the nursing school and the eventual necessity of providing a dental school for the State reinforces the need for a new library to a point which is now critical.

In regard to our applicants, this complex procedure of selecting medical students would be simplified if we could select accurately those students with a genuine interest and concern for people. Many of our other evaluating mechanisms could thus be placed in better perspective.

I will always remember the young physician that I was trying to persuade to enter the field of pathology. I knew he liked pathology and he had manifested a decided aptitude in his understanding of basic principles of disease. He finally blurted out that he wanted to take care of sick people, because as he said, "Making sick people feel better makes me feel good!"

As Owen[5] has succintly summarized, "We must strive to enroll whenever we find them, intelligent men who have a heightened sense of involvement with people, who are more interested in individuals than in humanity, and who see science as an avenue of approach to the sick patient and not the patient as a substrate for science".

I believe that in perfusing our students with the sound basic principles of medicine that this should in large part be accomplished by the observation, diagnosis and care of patients in the hospital and clinic rather than the instruction by research.

I fully realize that a strong research program serves as a stimulus to faculty and students. It enables them to develop analytical and inquisitive minds. Research activity fulfills an innate desire, possessed by many concerned with medical education, to pursue the quest for new knowledge. It thus fills not only a basic urge, but a fundamental responsibility on the part of medical institutions and their staffs to increase our knowledge

of disease and thus apply increasingly effective remedies.

It must not become a compulsory or obsessive component within an institution. It should not be emphasized simply because money is available. It is not necessary for every faculty member to be a research investigator and every student a research assistant. Those who teach well and care for patients competently in hospital bed or clinic cubicle are not second rate. We do not imply that these physicians should not be curious, probing and alert, but it is reasonable to expect that many of them prefer to exercise their skill and art at the bedside and leave the laboratory to confreres who prefer and are better designed by nature to conduct investigation. In assigning research to its proper place within the education framework, *it is not a question of making a choice but maintaining a balance.*

The same balance should pertain in viewing our educational objectives. Should the Medical College of South Carolina be a school designed exclusively for the production of general practitioners? Should we cerebrally flush away from all of our medical students any desire to proceed with speciality training? As a corollary, should we magnify the advantages of specialization and convert any would-be wanderer from the field of general medicine into the restricted pastures of specialty training? — The answer is, of course, obvious — *"to perfuse our students with the sound basic principles of medicine" so that after graduation they may proceed* with their preparation for general practice, specialty practice, mixed practice, teaching, research or such a combination as their aptitudes and motivation dictate.

Medical education has always been expensive and recent figures indicate that it is becoming more so. Faculty procurement is a case in point. Competition for adequate, not to mention superior, faculty members is becoming increasingly keen and costly. Instructors of promise now require basic stipends of from $10,000 to $12,000 whereas those of established competency in the professorial ranks cannot be attracted and retained unless salaries from $15,000 to $18,000 are provided.

The present rate of public support for medical schools is approximately $4,000 per year per student.[6] The costs of medical education are not fully understood by the general public. They fail to take into account the aspects of patient care. The fact that many sick people are cared for in the educational process should ameliorate the stringency of this indictment, if it be construed as such. The public is apt to compare the size of the graduating class in medicine with the size of the medical educational budget. They fail to grasp not only the concept, but the actuality of the medical school being the university of the health sciences in which the instruction of physicians is of paramount importance, but also encompasses the educational responsibility for many students in the allied health fields. These include pharmacists, nurses, medical technologists, physiotherapists, dieticians and a variety of technical assistants. We earnestly hope that in our institution it will soon include dentists. The number of interns, residents and postdoctoral fellows who gain additional experience and training in the medical school's principal teaching hospital may approach the size of the medical student body. At the Medical College of South Carolina the number of these trainee physicians is at least one fourth larger than the average graduating medical class and is constantly growing. The demand for graduate students in the biological sciences is steadily accelerating as research burgeons and the need for medical faculty personnel increases. These graduate students may receive all their training in the basic science departments of the medical school. This is an impressive contribution to the creation of professional and scientific talent and allows the medical school's budget, educational responsibility and scope to be viewed in the proper perspective. It is difficult to measure the monetary value of these contributions, but one medical school concluded that approximately one dollar out of every three of its educational budget was attributable to these activities.[7]

The large prospective increase in student body, increased faculty and administrative personnel, more adequate salary schedules, the cost of maintaining and operating a larger plant as well as generally rising costs will make necessary a continuing rise in state appropriations.

For a desirable expansion of the Medical College and the establishment of a School of Dentistry the capital requirements of the Medical College of South Carolina may reach $7 million within the next ten years.

It is essential that long range developmental planning encompass the student body, the faculty, the curriculum and physical facilities and all of these should be so projected as to fulfill the requirements for national prestige. Merit scholarship should be applied to institutions as well as individuals. The fact that a nationally known surgeon and educator is joining our ranks as Chairman of the Department of Surgery is a sign post as to our future.

An institution which generates pride on the part of its students, faculty, alumni, friends and community and state has an incalculable asset. This pride merges with morale and esprit de corps — without it virtually nothing can be accomplished, but with it the future is assured. This pride is based on the record of things accomplished, maintaining standards of excellence, doing a job well, and presages a continuing period of progress, service and accomplishment.

"Put your confidence in us . . . . .

"Give us the tools and we will finish the job."

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Book Reviews

PHYSICAL DIAGNOSIS. 6th Edition, R. H. Major and M. H. Delp. W. B. Saunders and Co. Philadelphia, 1962, 355 pages. $7.50.

This small text is written for medical students first undertaking study of clinical patients. The sixth edition is an attractively prepared book of modest size. The material is presented with many historic overtones which is possibly justified if the author's statement that "with the advent of Skoda's work (1839) the last great advance in physical diagnosis was made." The book begins with a section on the history in clinical medicine and a chapter on the meaning of pain follows. The general subject of inspection of the patient is briefly treated. The rest of the book is divided into twelve chapters in which brief mention of the physical findings and diseases of various organ systems is made. The book closes with an unfortunately cursory treatment of the neurologic examination.

This is an old book and a new cover. The pictures are ancient and show only the most glaringly obvious manifestations of far advanced disease. The text is excellent in so far as it goes, but it seldom calls on the newer physiology to explain phenomena observed. One wonders what there is about Grocco's triangle which, in 1962, calls for a page of text and an illustration. Careful physical examination remains one of the most potent diagnostic tools a physician has, and aquisition of skill in its application is as important today as it ever was. This book is a good but superficial treatment of the subject and is of introductory value only. It can be recommended only for the sophomore medical student. The illustrations in particular do not give one a fair picture of disease entities as they present today.

C. M. Smythe, M. D.

INTERNAL MEDICINE IN WORLD WAR II, Vol. I, Activities of Medical Consultants prepared under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General of the Army. U. S. Govt. Printing Office, Washington, D. C. 1961. Pp. 880. $7.50.

This is truly a monumental work which should be read with pleasure and interest by every physician who has served in the Armed Services.

It is made completely readable by the wisdom of the editor in removing little, if any, of the purely personal views and opinions of the many fine contributors.

This is a medical text only in a historical sense. What it actually represents is a very intriguing view of the reactions of physicians to the trials and tribulations of wartime military service.

William H. Amspacher, M. D.

COMMON SENSE ABOUT PSYCHOANALYSIS. Rudolph Wittenberg. Doubleday & Co., Inc. Garden City, N. Y., 1962. $3.95

This is a book for popular reading written by a practicing psychoanalyst who wishes to explain the common sense value of psychoanalysis. Since there are some who think there is much common sense and others who think there is very little common sense about psychoanalysis, this is a sort of middle ground treatment of the subject.

Psychoanalysis is for the favored few. The author says that it takes about 800 hours for an analysis at $20.00 an hour over a period of four or five years. This amounts to about $16,000.00, a sum which may be harder to get than is a little do-it-yourself treatment of the psychosis.

As for ourselves, we are rather inclined to seek the old-fashioned understanding family doctor than to prostrate ourselves on the psychoanalyst's couch. The search may be difficult.

J. I. W.

EARLY DETECTION AND DIAGNOSIS OF CANCER. Walter E. O'Donnell, Emerson Day, and Louis Venet. The C. V. Mosby Co., St. Louis, Mo. 1962, $12.00.

This book provides in clear, concise, outline form a wealth of information about cancer in all its various manifestations, with practical guides to the initial detection of various types of lesions and suggestions in regard to initiation of management. It does not go into any detail in regard to the wide variety of methods of treatment of specific lesions, which could fill several additional volumes.

The two initial chapters on "The Cancer Problem" and "The Cancer Detection Examination" merit perusal by medical students and practitioners alike. Illustrations of techniques of examinations are profuse and of the line-drawing variety, readily interpreted.

The remaining chapters, on cancers of specific locations, have a systemic organization, including data in regard to epidemiology and possible etiology, as well as clinical manifestations and specific modes of diagnosis.

This volume is unique in its field and should find a wide range of usefulness for specialists as well as general practitioners. It should serve as a useful reference on every doctor's bookshelf.

John C. Hawk, Jr., M. D.

MINUTES CONTINUED
HOUSE OF DELEGATES
Wednesday, May 9, 1962
Dr. Charles N. Wyatt, Presiding

Call to Order, 9:30 A. M.
THE CHAIR: Will the delegates take their seats, please?

I will ask the Credentials Committee, if they have a quorum, Jimmy Wells, how many do you have?
DR. WELLS: Around thirty (30) so far.

THE CHAIR: Gentlemen, we have a quorum, I am calling the House of Delegates into session.

Does the Reference Committee on Reports of Council and Officers have their report ready, Dr. Solomon?

DR. ROBERT S. SOLOMON: This is the report of the Reference Committee on Reports of Council & Officers. Motion was made by Dr. Tucker Weston, seconded by Dr. Harold Jeter and unanimously carried that the Reference Committee recommend that a committee be appointed by the President to study and report to council the advisability of a permanent committee to study medical education and all state agencies having medical advisory committees. I so move, Mr. President.
THE CHAIR: You have heard the motion, gentlemen, do I hear a second? (Seconded by Dr. Weston, there was no discussion, the vote was taken, and the motion passed.) It is so ordered. Proceed, Dr. Solomon.
Dr. Solomon (Cont. report) The following motion was made by Dr. Tucker Weston, seconded by Dr. Harold Jeter and unanimously carried: that the Reference Committee recognizes that the State Constitution prohibits dual office holding, and since the question has been brought up with reference to the State Board of Medical Examiners, that members of the S. C. Board of Medical Examiners should abide by the state law and that any such man holding office make a decision as to which office he shall hold (this applying to all members of the Board,) if such dual office holding is unconstitutional. I so move, Mr. President.
THE CHAIR: You have heard the motion, gentlemen, do I hear a second? (Motion seconded by Dr. Weston, there was no discussion, the vote was taken and passed and it was so ordered.)
(Dr. Solomon, continuing report) On Motion by Dr. Harold Jeter, seconded and unanimously carried the following reports were accepted: The reports of the Secretary, Executive Secretary, Editor of the Journal, Chairman of Council, the Delegates to A.M.A., Dr. Johnson, The Delegate to A.M.A., Dr. Weston, and the State Board of Medical Examiners. I move the acceptance of these reports as given, Mr. President.
THE CHAIR: You have heard the motion, gentlemen, do I hear a second? (The motion was seconded by several from the floor, there was no discussion, the vote was taken and motion passed and it was so ordered.
(Dr. Solomon, continuing report): The reference committee accepted as information the report of Council on telegraphing the three candidates for the United States Senate as to their stand on the King-Anderson Bill.
Mr. President, I move the acceptance of this Reference Committee report.

Respectfully submitted,
Robert S. Solomon, M. D., Chrm.

THE CHAIR: Gentlemen, do I hear a second? (The motion was duly seconded and passed and it was so ordered.)
Thank you very much, Dr. Solomon.
We will now have the Reference Committee report on Amendments to Constitution and By-Laws, Dr. Francis C. McLane, Chairman.

DR. McLANE: Mr. President. The motion by Dr. Waring to amend Chapter 8, Section 4 and Section 15 of the Constitution to require committee reports (including the program committee) to be submitted by the various committees sixty (60) days prior to the annual meeting, instead of thirty (30) days, to the Editor of the Journal is approved by this committee and we report to be in favor of its adoption. I so move, Mr. President.
THE CHAIR: You have heard the motion gentlemen, do I hear a second. (The motion was seconded by Dr. Prioleau, there was no discussion, it was voted on, passed and so ordered.) Proceed, Doctor.
DR. McLANE (Continuing report) The motion made by Dr. Gressette for the increase of councilors from 9 to 15 in order to correspond to the new Judicial rather than Medical Districts should be referred to a Special Committee and given further study and resubmitted as unfinished business at the next session of the House of Delegates in 1963, and I so move, Mr. President.
THE CHAIR: You have heard the motion, gentlemen do I hear a second? (The motion was seconded) Is there any discussion?
DR. MAYER (Recognized) Mr. President, who appoints the committee?
DR. McLANE: I suppose the president of the association. I make that as a motion that the president of the association appoint this special committee.
(Question from the floor) Any special number on the committee?
DR. WESTON: Mr. President, I think it ought to be not more than five (5).
DR. McLANE: I accept that.
THE CHAIR: You have heard the amendment—the motion is that the president appoint a committee of not more than five (5) to study this recommendation and bring it back next year as unfinished business. Does the seconder of the original motion accept this amendment? (Dr. Eaddy stated he would accept the amendment. There was no further discussion, the vote was taken, the motion passed and it was so ordered.)
Thank you very much Dr. McLane.
The committee on Insurance, Blue Cross-Blue Shield, are you ready to report?
DR. MICHAEL PATTON. Chairman: Yes, sir. This is the report of the Reference Committee on Insurance, Blue Cross, Blue Shield. The report from the Hospital Insurance Committee as published in the South Carolina Medical Association's *Journal* was received with thanks.
Dr. James Wells and others appeared before the committee pleading for standardization of insurance forms and this committee recommends that a committee be appointed to communicate with the South Carolina Insurance Underwriters Association and invite action towards this end. Should such a committee be appointed your reference committee recommends that it study a plan known as the "Individual Responsibility Plan" which originated in the Los Angeles County Medical Association and which was brought to our attention by Dr. Thomas Parker. (Details concerning this plan will be available to this committee from Dr. Thomas Parker of Greenville, S. C.) I so move, Mr. President.

Signed: Michael Patton, Chairman
R. M. Fuller, John Siegling, Joel Wyman (Committee)

THE CHAIR: Dr. Patton, by whom is the committee to be appointed, by the president, Council or whom? Would you specify?

DR. PATTON: The President. There is some misunderstanding, some confusion about this, I recall about two years ago that a committee was appointed and we haven't been able to find it in the minutes, anything in the last year's minutes with reference to the report of that committee, if that committee is still functioning you wouldn't need this one.

THE CHAIR: You make this as a recommendation. Gentlemen, you have heard the motion. (The motion was seconded from the floor, there was no further discussion, the vote was taken, the motion passed and it was so ordered.

DR. PATTON: That concludes the reference committee's report.

THE CHAIR: Thank you Dr. Patton. Is the Reference Committee on Public and Industrial Health ready to report? Dr. Tiller?

DR. TILLER: This is the report of the reference committee on Public and Industrial Health. Dr. Jervey appeared before the committee from the Committee appointed to study injuries from lead pellets. Our committee proposes that the committee on lead pellets be continued. I so move.

THE CHAIR: Gentlemen, you have heard the motion, do I hear a second? (It was seconded, there was no discussion, the vote was taken, passed and it was so ordered.)

DR. TILLER (Continuing report) Dr. Ball and Dr. Talbert of the Charleston County Medical Society appeared in favor of a resolution on the floor, which was presented yesterday. I will read this resolution as it is stated in better words than I can put it in. It was a resolution regarding Mental Health Legislation (Reading resolution presented by Dr. Pettit) Be it resolved that a standing committee on mental health legislation be appointed by the President, and reappointed annually. It shall be the duty of the committee to review existing state laws concerning the mentally ill, to study new state and federal bills pertaining to the care of these patients, and to keep the members of the state association informed about the provisions and potentials of such legislation.

The Charleston Medical Society has presented this little pamphlet regarding this resolution and apparently there is quite a bit to this that doesn't meet the eye. In 1961 the South Carolina Legislature, without the knowledge of too many of us, passed an Act to provide for the establishment of community mental health services programs. And of these 19 pages I would like to read a paragraph concerning this Act. This committee of the Charleston County Society points out that (reading) "the Act itself does not provide for any medical personnel whatsoever as a requirement of a community mental health program. Nor does the Act itself provide for the Program Director or a Medical Director. These are left entirely to the discretion of the South Carolina Mental Health Commission. The question, therefore, arises as to whether these are adequate provisions to safeguard the principle that care of the mentally ill remain in the hands of the medical profession. The committee recommends that amendments be sought to the Act.

Our Committee reviewed this pamphlet and we recommend that all members of the state association read this.

Our committee recommends that the resolution No. 5 regarding a standing committee on mental health legislation be adopted, and I so move.

THE CHAIR: You have heard the motion, gentlemen, do I hear a second? (The motion was seconded by several, there was no discussion, the vote was taken, passed and it was so ordered.) Proceed Dr. Tiller.

DR. TILLER (Continuing with report) Mr. President, that concludes our reference committee report. I move that this report be adopted.

THE CHAIR: You have heard the motion, is it seconded? (There were several seconds, the vote was taken, passed and it was so ordered.) Thank you Dr. Tiller.

THE CHAIR: At this time, gentlemen, I would like to have Mr. Joe Miller on AMPAC, he will explain the situation to you.

MR. JOE MILLER: Thank you, Dr. Wyatt, I assure you delegates that I will only take ten minutes of your time. I had an opportunity this morning to meet with your councilors. I want to take a few minutes on behalf of Dr. Johnson and members of the Board of Directors of the American Medical Political Action to talk to your briefly about this organization, what it has done and what it hopes to do and how it wishes to work with a committee in this State.

The American Medical Political Action committee might be defined, in a nut shell, as being a COPE-type organization. Actually this is the second large national organization to be formed under the provisions of the Federal Broad Practices Act. Of course, labor has had this type of activity for a number of years. But AMPAC had its beginning about eight months ago and at the present time we can report that there is a cooperating activity of some type in 41 states, and we have had considerable degree of success with our membership program and our financing of this activity.

Membership in AMPAC is available to physicians and their wives and members of their immediate family, as well as others. AMPAC is not affiliated with either major political party, it is not bound by Democratic or Republican Party labels. The program and platforms of the individual candidates will determine whom the free committee supports, not the candidate's party affiliation. It might interest those of you in this room to know that my Board if 10 members is a varied bi-partisan board; I could tell you the division is a toss-up between the two major parties. It also may be of interest to you that AMPAC will function independently of all medical societies and associations, but that statement in itself is a little misleading. We say quite often that AMPAC, as far as its relation with A.M.A. goes, will work separately but together. Actually this organization is created for one purpose: to help medicine develop a mechanism or activity which can not function through corporate organizations such as your own here, or a county medical society. This is true of any corporate group, whether it be for profit or non-profit; as such they can not participate in candidate or campaign activities.

This is AMPAC's chartered responsibility to support existing legislative programs of organized medicine, and to provide to you and your wives a program that will help you effectively concentrate your material resources in a selective number of terminate areas across this country.

I might say for this year, 1962, which is a crucial election year, your national committee will in all probability participate in some 50 to 70 congressional races. Primarily, emphasis is being placed upon the House races, rather than Senate races, though there are a few key senatorial races that this committee will concern itself with.

The National Committee does not intend to become involved in local legislative races. This the committee feels is the primary responsibility of a state political action committee and we will hope that you, all of you, as representatives of the medical profession in this state, would give serious consideration to a state medical political action committee, that would work in harmony and conjunction with our national committee.

You might like to know how these funds are spent.

First of all AMPAC has an educational program and secondly it has a political action program. The educational phase of this activity will be devoted to a number of things, for example, our first news letter will be available at the time of the AMA meeting in Chicago, beginning June 24. This committee will also prepare and distribute to you, on request, a seminar or say a course in political actions for physicians and their wives, which can be used at the county society level or at House of Delegates level. We will have a team of staff people, from the national committee's office on request to put on this program if you so desire. The committee is also assuming responsibility for analyzing voting records and disseminating them to local groups on request, as another part of our educational program. There are many other activities that fall in the educational classification that I will not go into at this moment.

As to the political action phase of this program, of course, this year is vital to organized medicine and your national committee is hard at work now already participating in a few of these activities and we are identifying locations and sources, etc. I can assure you that this committee will have some impact upon the congressional situation as it developes during this election year.

As to membership in the National Committee, our dues structure is a specific one and we would hope that at the state level a committee which is not officially a part of this state organization, present here today, would set up a similar activity and a dues structure for the state committee because you will need financing for state needs as well as AMPAC needs financing for national needs.

In order to be a member of the national committee our office must receive $10 or more from the individual contributing. Any amount between $10.00 and $98.00 will identify you as an active member of this organization; this is annual membership. We have a sustaining membership which is available to you and your wives and your sons and daughters. This also begins at $99.00 and for any amount in excess of $99.00 and less than $5,000.00 we will identify you as a sustaining member. Why the $5,000.00? I haven't had much problem with this one, gentlemen, but that is the maximum limitation posed by the Federal Law for a contribution to a particular candidate or political action committee.

We would very much hope the wives would take an active part in this organization and we have on our national committee a representative of the Woman's Auxiliary to the A.M.A.

We would hope that in any plans you might develop here that you would consider like representation on your own state committee.

It all boils down to this—now is the time your money, your effort and your support is vitally needed.

THE CHAIR: Gentlemen, you have heard the explanation of AMPAC, what is your wish?

DR. GRESSETTE (Recognized) After hearing Mr. Miller talk about politics—South Carolina seems to be a good political area—whether we would follow the pattern that they would set forth or not is a matter of individuality and I am not going to give the Democrats or the Republicans very much time today, are you doctor?

THE CHAIR: Not a bit.

DR. GRESSETTE: Not a bit, well anyhow I think it would be in order for the state medical association to go on record as endorsing such an action, commending such an action and leaving it as such, and then not talking about it and then suggesting that those who are interested, immediately after this morning session, assemble themselves over in the far corner and talk about it and maybe appoint a committee to activate such a committee. Can I move or can I resolve the point?

THE CHAIR: You can move.

DR. GRESSETTE: I would like to move that we pass a motion commending the committee's action and what it is trying to do for organized medicine and stop with that, and then I want to remind you that I think it will be a good idea for us to meet afterwards or to tell the officers, for the coming year, to appoint a committee to activate such. I think it would be in order to have such a committee at this time.

THE CHAIR: You make that in the form of a motion, doctor?

DR. GRESSETTE: Yes, in the form of a motion. (This was seconded by Dr. Weston. When discussion was called for Dr. Patton was recognized.)

DR. PATTON: I have a question, is this committee going to be under the policies of the A.M.A. or would it develop its own policies as it goes along?

MR. MILLER: Let me answer the question in this way, there is a very definite relationship between the A.M.A. and this committee. Our board is appointed by the Board of Trustees of the A.M.A. and some of our activities, our educational activities are financed by your A.M.A. association. The Board is subject to reappointment each year, I can assure all of you in this room that this Board serves its own purposes and it is not directed by the A.M.A.

THE CHAIR: That answers your question, Dr. Patton?

DR. PATTON: Yes, sir.

THE CHAIR: Any further discussion? (Dr. Tom Parker is recognized.)

DR. PARKER: Mr. President, life is so complex these days we have to try to get our organizations straight. The American Medical Association is primarily a scientific organization and it gets into questions of economic and politics both reluctantly and unhappily. The Association of American Physicians and Surgeons, whose members have to be physicians and eligible for A.M.A. membership, whether they are members or not, some of them are not, is primarily concerned with economics and the education of the people, but it is not a political organization in the sense that as an organization it supports a given candidate. Its members support people but as an organization it doesn't. This organization, AMPAC, is primarily a political organization and as Mr. Miller pointed out the organization of such a group for these purposes is in accord with existing law and it is necessary to comply with existing law and it is for the purpose of meeting such a situation as we had in Greenville, right now, in that district, the sixth congressional district. Congressman Ashmore is our really good congressman, he happens to be one of our two most conservative, he and Congressman Dorn, vie as to which one is the most conservative in their voting records, but we can not get Congressman Ashmore to come out and take a stand on the King-Anderson bill, and we are only able to approach him as individuals. In this organization we could approach him as an organization which, I believe, would be helpful to us. I think we ought to support it very vigorously.

THE CHAIR: Any further discussion? Do I hear a question? (Question from the floor)

THE CHAIR: Those in favor of the motion stated by Dr. Gressette let it be known by saying "aye". (The vote was taken, there were no "noes", and it was so ordered.)

I would like to ask if Dr. Cone from Sumter is here? I would like to know if the Committee on Legislation and Public Relations is ready to make their report, Dr. Cantey?

DR. SAMUEL O. CANTEY, JR. (Recognized): "Report of Reference Committee on Legislation and Public Relations."

1. The Report of the Standing Committee on Legislation and Public Relations was reviewed and it is recommended that it be accepted as information. (This motion was seconded, there was no discussion, the vote was taken and it was passed and so ordered.)
2. The report of the Committee to Study Current Efforts and Facilities of the A. M. A. along Public Relations Lines was considered. It is recommended that the members of the committee be thanked for serving and that the committee be abolished. I so move.
(The motion was seconded from the floor, there was no discussion, the vote was taken, motion passed and it was so ordered.)
3. The report of the Coroner-Medical Examiners Systems Committee was studied and this Reference Committee approves its findings and recommendations and advises that this problem be referred back to the Standing Committee on Coroners-Medical Examiners Systems for concrete proposals. I so move.
(The motion was seconded from the floor, and discussion called for.)
(Request from the floor that the motion be restated)
DR. CANTEY: It approved the findings and recommendations of the Standing Committee and advises that this problem be referred back to the Standing Committee on Coroners-Medical Examiners Systems for concrete proposals.
(Question from the floor—What were the findings you approved?)
DR. CANTEY: In brief, the standing committee found that our present system was inadequate, in a general way they recommended setting up a central laboratory in cooperation with SLED, Clemson and the Medical College. They thought that the process of setting up a Medical-Coroners System, such as Virginia and some other states have, would be too costly at this time. In other words, the recommendation is that we improve our Coroners System with better facilities for autopsies and toxicological studies, etc., and the committee has made rather general recommendations and didn't say how to do it.
THE CHAIR: Does that explain the situation? Is there any further discussion? (There was none, the vote was taken, the motion passed and it was so ordered.) Proceed doctor.
4. The report of the Public Relations Committee was presented by Dr. Waring. It is recommended that the program be approved and that a maximum of $5500.00 be appropriated to continue this work. I so move.
(This motion was seconded and discussion called for.)
DR. WESTON (Recognized): Is that on a competitive basis, Mr. President, in regards to what company shall handle it?
THE CHAIR: As I understand the motion it was left with the public relations committee.
DR. WESTON: Well, I think it ought to be on a competitive basis. I think if one company wants to bid for it against another company they have a perfect right to.
THE CHAIR: Well, that may be so, Dr. Weston, whichever way the thing was brought up it was left to the discretion of the Public Relations Committee to handle the situation, it was thought that was the best way. Dr. John Brewer, Chairman of Council was called. Dr. Brewer, the Public Relations Resolution that you introduced in Council, giving them—it is my impression the Public Relations Committee had the authority to expend that money, not to exceed $5500.00?
DR. JOHN BREWER: That is correct.
THE CHAIR: It was left to their discretion as to who to use and anything else?
DR. BREWER: That is correct, under the chairmanship of Dr. Joseph I. Waring to select or use anybody he so desires.



Dr. Ben Miller, new secretary.

THE CHAIR: Any further discussion? (There was none, the vote was taken, motion passed and it was so ordered.) Proceed Dr. Cantey.
5. The Resolution from the Anderson County Medical Society regarding the retirement policy of the State of South Carolina in respect to its employees was discussed. Due to varied opinion as to what the state's policy actually is, it is recommended that the matter be investigated by our legal advisor, Mr. Meadors. I so move.
(The motion was seconded by Dr. Cain, there was no discussion, the vote was taken, the motion passed and it was so ordered.)
6. The Resolution from the Anderson County Medical Society regarding the "Good Samaritan Law" was considered. This committee found merit in this proposal and recommends that council study this matter further during the coming year with the view of having such a law enacted. I so move.
(The motion was seconded by many, there was no discussion, the vote was taken, motion passed and it was so ordered.)
7. The Resolution from Charleston County, that the South Carolina Medical Association go on record as being opposed to the King-Anderson bill was approved, and it is moved that it be adopted.
(The motion was seconded by many, there was no discussion, the vote was taken, motion passed and it was so ordered.)
THE CHAIR: That completes your report, Dr. Cantey?
DR. CANTEY: Yes, sir.
THE CHAIR: Thank you, sir. I will now ask for the report of the Reference Committee on Miscellaneous Business, Dr. William H. Williams, Jr., Chairman.
DR. WILLIAMS: (Reading report) The Committee on Miscellaneous Business:
I. Reports of the following committees are approved and accepted as published:
A. Medical Advisory Committee to Selective Service.
B. Committee on Cancer.
C. Liaison Committee.
D. The Committee on Historical Medicine.
E. Committee on Liaison with Allied Professions.
F. Committee on the Woman's Auxiliary of the Medical Association.
G. Committee on Rehabilitation.



Dr. Robert Wilson, president elect, and Dr. Gressette, president.

(Ed. Sorry, this is the best of several pictures of Dr. Gressette.)

H. Benevolence Fund Committee.

I move you sir that this recommendation be accepted. (This was seconded, there was no discussion, the vote taken, motion passed anl it was so ordered.)

II. Reports as published and supplemental reports and recommendations as presented by the following committees are accepted and approved:

A. The Medical Advisory Committee to the Crippled Children Society of South Carolina.

B. Committee on Disaster Medical Care.

I move you sir that this portion of the report be accepted.

(This motion was seconded from the floor, there was no discussion, the vote was taken, motion passed and it was so ordered.) (Dr. Williams proceeds with report)

III. Report of the Committee on the American Medical Education Foundation accepted and approved with the following addition:

In many communities the major effort in behalf of the A.M.E.F. is made by the Woman's Auxiliary of the Medical Association. The Auxiliary, therefore, is to be heartily commended for this effort. It is recommended that a letter expressing the gratitude of the Association and the A.M.E.F. committee for this work be forwarded to the Woman's Auxiliary of the South Carolina Medical Association.

I move you sir that this portion of the report be adopted.

(The motion was seconded, there was no discussion, the vote was taken, the motion passed and it was so ordered.)

(Dr. Williams continues)

IV. Resolution four as presented by the Anderson County Medical Society is accepted as information. The Committee agrees entirely with the sentiments expressed in the resolution regarding the invaluable service rendered by the members of the South Carolina Highway Patrol in matters of safety, first aid and rescue operation. However, matters of pay scales and recommendations for salary changes of public officials is deemed not within the sphere of influence of this Association.

I move you sir that this recommendation be accepted. (The motion was seconded by Dr. Weston and others, there was no discussion, the vote was taken, motion passed and it was so ordered.)

DR. WILLIAMS: I move you sir that this committee report be accepted as a whole.

(The motion was seconded by many, there was no discussion, the vote was taken, motion passed and it was so ordered.

THE CHAIR: Thank you Dr. Williams.

At this time we come to the question of re-registration, Gentlemen, you recall that at the annual last year it was decided that a referendum be held among the County Societies and this to be voted on, the resolution, at this meeting. About six weeks or two months ago the secretary of each county society was sent a copy of this resolution and we requested you to be ready to vote, and I now ask you to vote on the Aiken Resolution, as postponed from last year. Before we take the vote I hope there is no discussion but if there is now let it be on.

DR. GEORGE A. PODA: (Recognized by The Chair) As you all know the problem of registration and re-registration has been before us quite a few years. Last year Aiken County looking into this thing made quite an exhaustive study of various legislation of various other states. We find that South Carolina is one of the few states that does not have a re-registration act. The proposal that we made we feel is one that will suffice for re-registration but also give protection to the individual physician. I would like to at this time propose that we adopt this rather than wait and have something that we don't like crammed down our throats at a later date by legislation.

THE CHAIR: Is there anything further from anyone? If not, gentlemen, I would like all those in favor of the Aiken resolution on re-registration to please stand. I will ask the tellers to count the votes. Please remain standing until you are counted.

(After the "ayes" are counted.) All right, those opposed please stand, those opposed to re-registration as presented by the Aiken group. (The count is made) Be seated, please.

The vote is as follows, fifty-seven (57) for, twenty-one (21) opposed, therefore the resolution is adopted. (Applause)

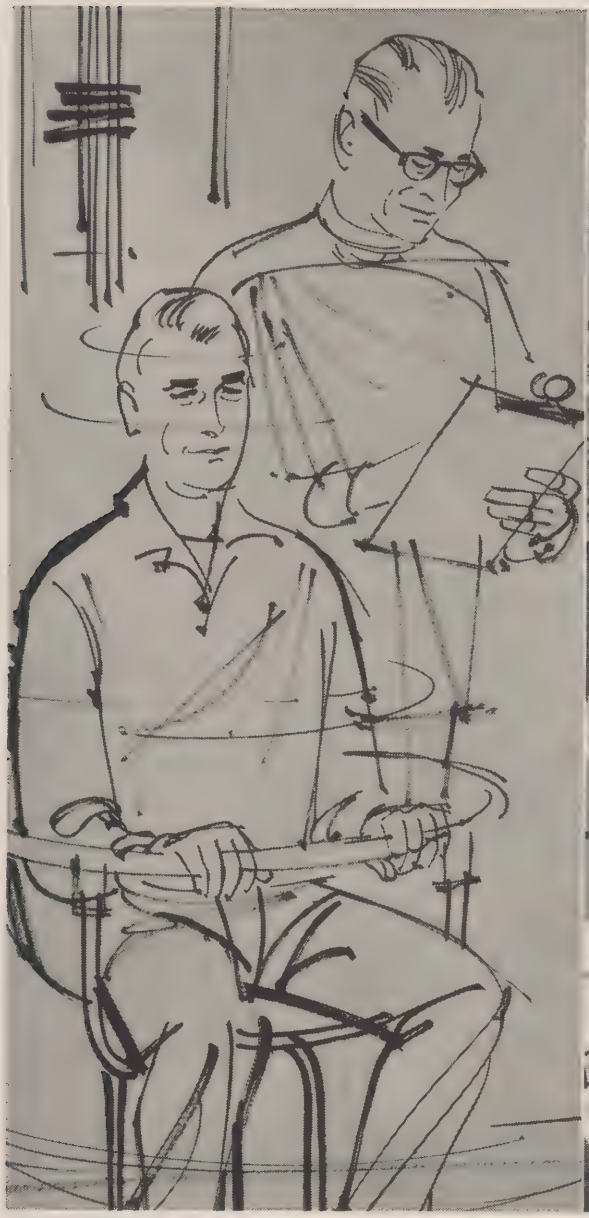
DR. JOE CAIN (Recognized): Members of the House of Delegates, I would like to ask your permission—I would like to make a motion to the effect that we reconsider an action taken earlier this morning concerning the Board of Medical Examiners and I believe that you will agree that my reasoning is sound. The question arose as to whether two members on our board are serving in dual capacity and we have information at the present moment the Attorney General is still trying to make that decision—that decision has not yet been made, he is present in the hotel this morning and at the time this discussion came up we were working with him trying to iron the situation out so that any indication that he has made a ruling on the case already is erroneous and I would like to ask you to hold this matter in abeyance until the time for election which will be maybe 30 or 40 minutes or an hour from now at which time he may have made his decision and it will be known to us.

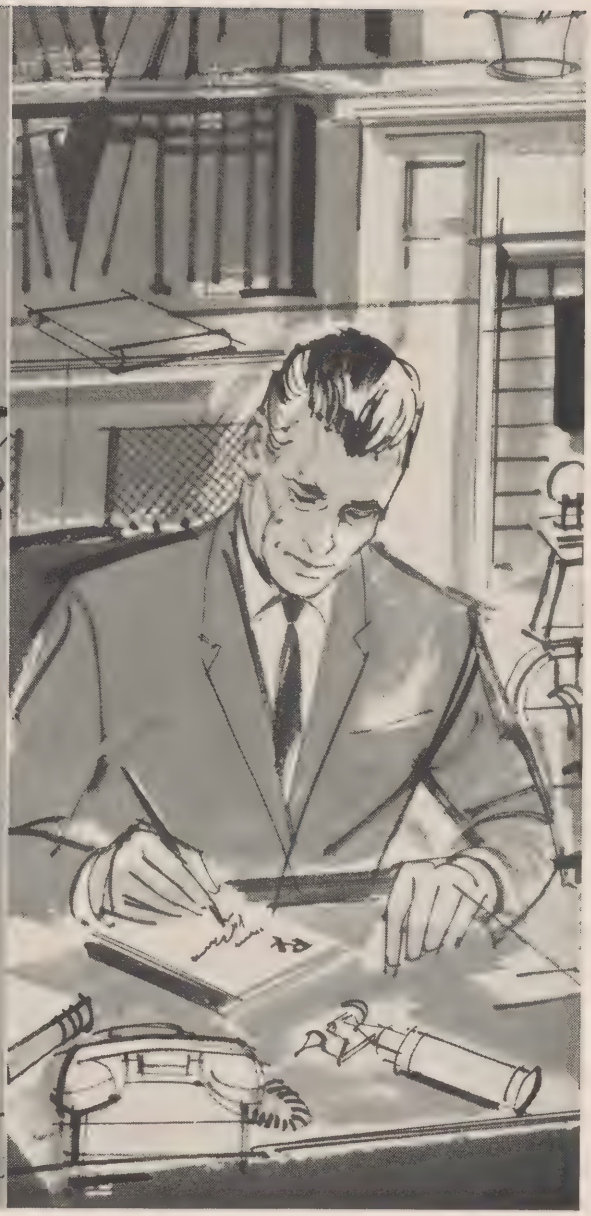
Mr. President, I would like to make a motion that we reconsider our action in view of the present knowledge and hold it in abeyance until time for the election of the board.

(This motion was seconded by many from the floor and discussion called for.)

DR. SOLOMON (Recognized — Chairman of the Reference Committee on Reports of Council and Officers)

Mr. President and members of the House of Delegates with reference to what Dr. Cain has just put in





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the record, I would like to re-read the motion that was passed, it was made by Dr. Weston and seconded by Dr. Jeter (Reading) "the reference committee recognizes that the State Constitution prohibits dual offic holding, and since the question has been brought up with reference to the State Board of Medical Examiners, that members of the S. C. State Board of Medical Examiners should abide by the state law and that any such men holding dual office make a decision as to which office make a decision as to which office he shall hold, if such dual office holding is unconstitutional."

We left this all in the question.

THE CHAIR: Joe, you withdraw your motion?
DR. CAIN: Yes, I withdraw the motion.
THE CHAIR: At this time, gentlemen, I would like to make an announcement. It will be made again this afternoon, that the luncheon for tomorrow has been called off in the panel discussions, however, these panel discussions will be held in the private dining room, starting at 12:45 P. M., I mean in the main dining room and there will be letters on the table running from "A" through "H" and you can locate your table and be there promptly at 12:45. As far as luncheon is concerned you can be served in the dining room anywhere you wish.
At this time I would like to recognize Dr. John Brewer, Chairman of Council.
DR. JOHN BREWER: Mr. President, members and delegates to the South Carolina Medical Association, several years ago Council adopted a plan of passing on, as a little memento of their past services, this plaque which we present each year to the outgoing president and also the vice-president. Dr. Charles Wyatt, who has so ably served us throughout the past year, and has made the going, I would say, very smooth for Council and all of its members, extending to us all his active and sincere cooperation, we greatly appreciate it, so Dr. Wyatt, the South Carolina Medical Association presents to you this certificate of office which so states (reading) "President, 1961-1962, Chairman of Council, 1959-1960." (Applause) This plaque is to our most able Vice-President, who is not with us this morning, Dr. Wallis D. Cone of Sumter, which states "Vice-President 1961-1962." Thank you. (Applause)
THE CHAIR: Thank you, Dr. Brewer, that brings us up to schedule with about 30 minutes to spare. If there is nothing of any importance to come before this group I will declare a recess until 11:00 o'clock at which time we will reconvene in this room and proceed with some business and the election of officers and a place of meeting next year. Please be back promptly at 11:00 o'clock.

(Recess until 11:00 o'clock)

(TO BE CONTINUED)



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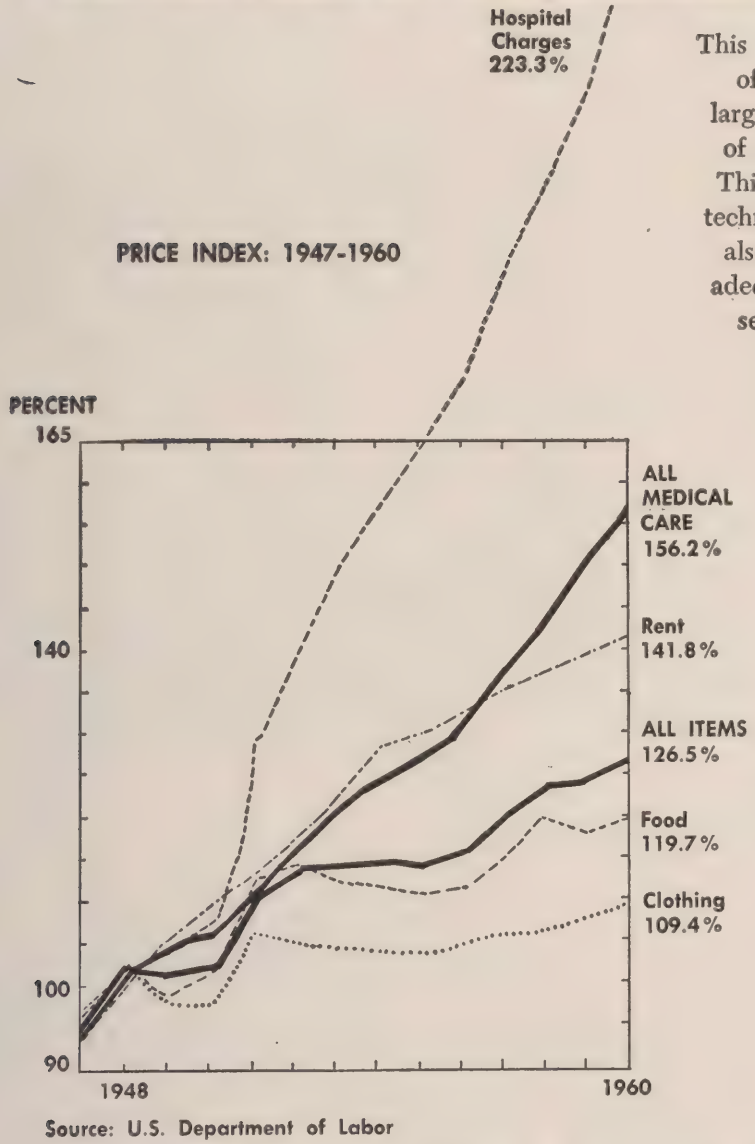
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This need leads to another — the need for the physician's "involvement." The AMA's *Principles of Medical Ethics* states:

"The responsibilities of the physician extend not only to the individual but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the welfare of the individual and the community."

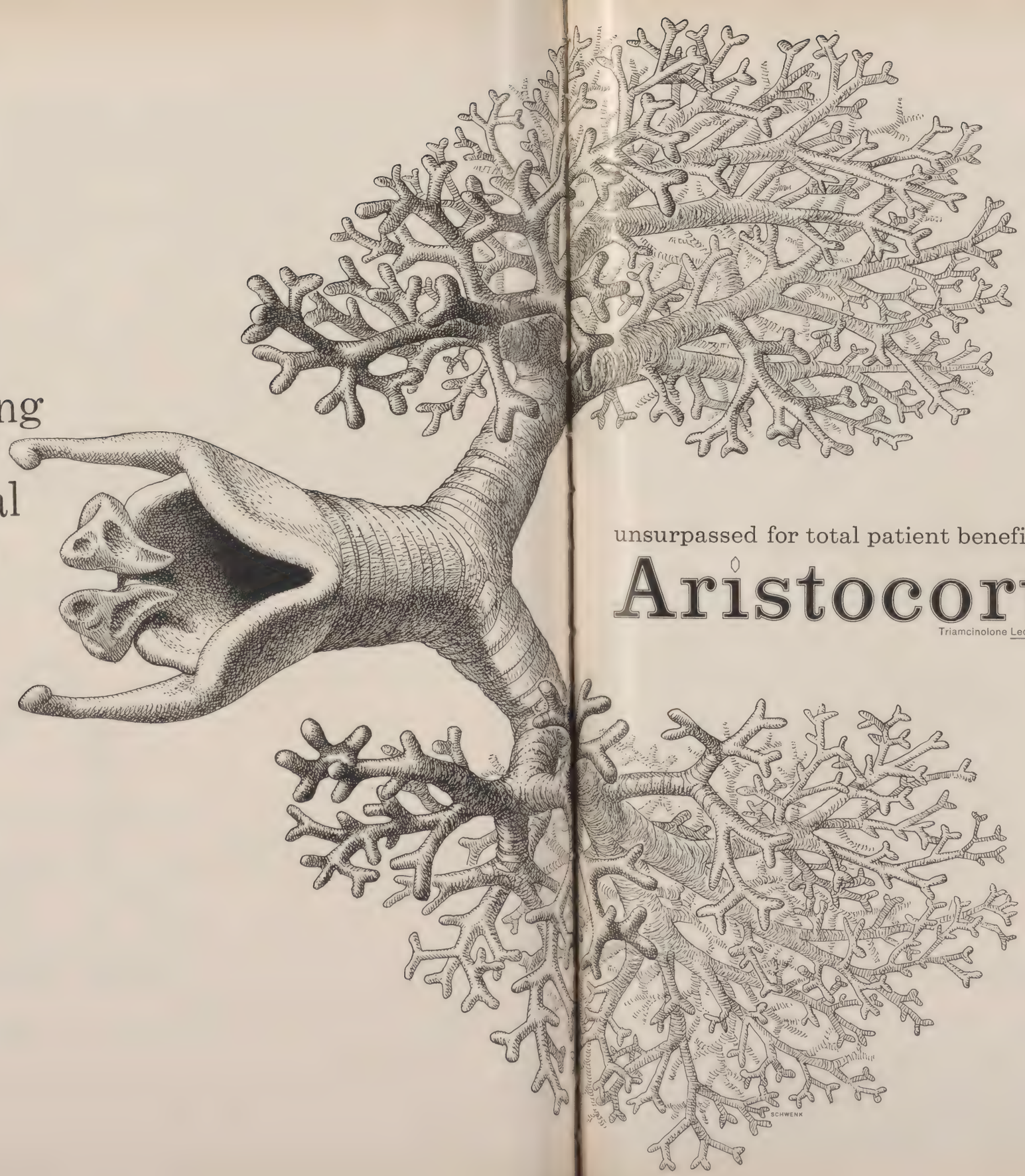
Counselling your patients on the value of an effective Blue Cross-Blue Shield pre-payment program is one very important way in which you can become constructively "involved."

Preserve the free practice of Medicine — Promote Blue Shield

S. C. MEDICAL CARE PLAN

709 SALUDA AVENUE, COLUMBIA, SOUTH CAROLINA

gratifying
relief
in bronchial
asthma



unsurpassed for total patient benefits

Aristocort®

Triamcinolone Lederle

With ARISTOCORT, asthmatic patients obtain sustained relief of wheezing, dyspnea, and spasmodic coughing. It is of particular value in ameliorating severe attacks that may have serious sequelae. With ARISTOCORT, many patients who might otherwise be invalids are able to continue their customary livelihoods or maintain their regular household activities. Yet this symptomatic relief is not often accompanied by the hormonal collateral effects —sodium retention, edema, emotional disturbance, insomnia, voracious appetite— that so often have been a deterrent to steroid therapy.

SUPPLIED: Scored tablets (three strengths), syrup and parenteral. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York

Stelazine® will stop anxiety—but not your patient!
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

SK&F





Diet patients find an incentive in appetizing "bulk" foods like these.

How to help your patient stick to a "regularity" diet

The secret ingredient in a successful diet is acceptance. Bulky foods, essential to a "regularity" diet, will have more appeal if they are attractively prepared.

Variety helps a patient follow a diet enthusiastically, too. Chilled orange and apple compote is inviting, rich in cellulose and pectin which absorbs fluid to form smooth bulk. Beets and carrots are also good pectin sources.

Cranberries can be added to oatmeal muffins to give the dieter cellulose plus Vitamin B complex. And liquids are vital, of course—8 to 10 glasses a day.



A glass of beer can add zest to a patient's diet

8-oz. glass supplies about 1/6 minimum Niacin requirements and smaller amounts of other B Complex Vitamins (Average of American Beers)

United States Brewers Association, Inc.

For reprints of this and 11 other diet menus, write us at 535 Fifth Avenue, N.Y. 17, N.Y.

If you have patients on a cholesterol depressant diet, this will be welcome news:

General Mills is now making available, through grocery stores, a Safflower Oil which is totally acceptable in the diet, and which is priced reasonably.

SAFF·O·LIFE
Safflower Oil



As you know, Safflower Oil is higher in poly-unsaturates and lower in saturated fats than any other type of readily available vegetable oil.

When an increased poly-unsaturated fatty acid intake is desirable, you can recommend Saff-o-life Safflower Oil. You can do so with the assurance that the patient will find it completely appetizing—clear, light and fresh-smelling—and priced at a level which poses no problem.

Ratio of Linoleates* to Saturates
*(Poly-Unsaturates)

SAFFLOWER OIL • 9.0 to 1.0
CORN OIL • 5.3 to 1.0
SOYBEAN OIL • 3.5 to 1.0
COTTONSEED OIL • 2.0 to 1.0
PEANUT OIL • 1.6 to 1.0

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to General Mills, Inc. Address your inquiries to Professional Services Director, General Mills, Inc. Dept. 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

DQ-2



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SINGLE PACKAGE OFFERS THE PROFESSIONAL MAN THE MOST COMPLETE, MOST CONVENIENT COVERAGES EVER!

Choose from over 40 kinds of protection, pack those you need into a single St. Paul Multi cover Plan. Deal with just one agent . . . pay just one premium. It's simple and safer, too.

Avoids overlapping coverages or loopholes between individual policies. Write for explanatory booklet.

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. Charman Carroll, M. D.
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Clinical Director
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"opened nose clear to the ears"[1]



This was how one patient described the nasal decongestant action of Dimetapp Extentabs. How would *your* patients describe it? From the first tablet, Dimetapp Extentabs provide prompt and prolonged relief from the stuffiness, drip and congestion of upper respiratory conditions, with exceptional freedom from side effects. The reason is in the formula: the potent antihistamine with side effects as few as placebo,[2] DIMETANE® (brompheniramine maleate, 12 mg.) and two outstanding decongestants, phenylephrine HCl (15 mg.) and phenylpropanolamine HCl (15 mg.)...all in dependable, long-acting Extentab form.

NEW DIMETAPP ELIXIR (one-third the Dimetapp Extentabs' formula in each 5 cc.), for conventional t.i.d. or q.i.d. dosage in a palatable, grape-flavored vehicle.

References: 1. Clinical report on file, Medical Department, A. H. Robins Co., Inc. 2. Schiller, I. W., & Lowell, F. C.: New England J. Med. *261*:478, 1959.

for nasal decongestion **Dimetapp® Extentabs®**

in sinusitis, colds, u.r.i., up to 10-12 hours' clear breathing on one tablet

A. H. ROBINS CO., INC., RICHMOND 20, VA.





The illustration: To dramatize the pain and trauma and healing of the peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch and photographed it, then repaired the damage and rephotographed the result — the "healed" ulcer.

ulcer under repair

"What results can I expect in my ulcer patients?" Shown below is a tabulation of 795 ulcer patients, reported by 69 investigating physicians, in which glycopyrrolate was the anticholinergic employed. They represent a cross section of ulcer patients of all ages, both ambulatory and hospitalized, under various regimens, from all sections of the country.

Note the pattern of results. Robinul showed an "excellent" or "good" response in over 83% of patients, and Robinul-PH provided similar results in 81%.

As for side effects, these often troublesome extensions of anticholinergic action such as dry mouth, blurred vision, etc., were evaluated as "moderate-to-severe" in only 6.7% of a total of 1705 patients in preliminary investigative studies, 795 of whom are the ulcer cases tabulated here.

We invite you to try Robinul in your own practice. We believe you will find it one of the most effective agents you have ever used for the management of the ulcer patient.

Robinul® (formerly Robanul)
Each tablet contains glycopyrrolate, 1.0 mg.

Robinul®-PH (formerly Robanul-PH)
Each tablet contains glycopyrrolate, 1.0 mg.; and phenobarbital (¼ gr.), 16.2 mg.

Robinul® at work

Brand of glycopyrrolate, Robins

results with Robinul and Robinul-PH in 795 ulcer patients, from 69 clinical investigators*

DIAGNOSIS	ROBINUL					ROBINUL-PH				
	*No. Patients	Excellent	Good	Fair	Poor	*No. Patients	Excellent	Good	Fair	Poor
Marginal Ulcer	11	3	3	3	2	1	0	1	0	0
Pyloric Channel Ulcer	6	3	1	0	2	2	1	1	0	0
Pyloric Ulcer	4	2	1	1	0	1	1	0	0	0
Gastric Ulcer, bleeding	3	1	2	0	0					
Gastric Ulcer	48	31	11	1	5	12	5	7	0	0
Gastric Ulcer, penetrated	1	0	1	0	0	1	1	0	0	0
Gastric Ulcers, multiple	1	1	0	0	0					
Duodenal Ulcer	494	220	195	48	31	99	41	38	13	7
Duodenal Ulcer, bleeding	38	19	15	3	1	2	1	0	1	0
Duodenal Ulcer, obstruction	13	4	3	1	5					
Duodenal Ulcer, perforated	5	2	1	0	2	6	0	3	1	2
Gastric and Duodenal Ulcer	4	2	2	0	0					
Peptic Ulcer, unspecified	25	19	4	0	2	18	8	7	2	1
TOTALS	653	307	239	57	50	142	58	57	17	10
		83.6%					81.0%			

*Clinical reports on file, A. H. Robins Company, Inc.

A. H. Robins Co., Inc.
Richmond 20, Virginia

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



Liquid asset

Now that we have added a new liquid-dosage form to our Panalba* family, you may prefer to begin treatment with Panalba KM* Drops when dealing with bacterial infections of unknown etiology in infants and children. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most bacterial infections of unknown etiology, Panalba offers excellent chances for therapeutic success—and why it should be your antibiotic of *first* resort.

Supplied: Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:

Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.

Usual pediatric dosage: ½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.

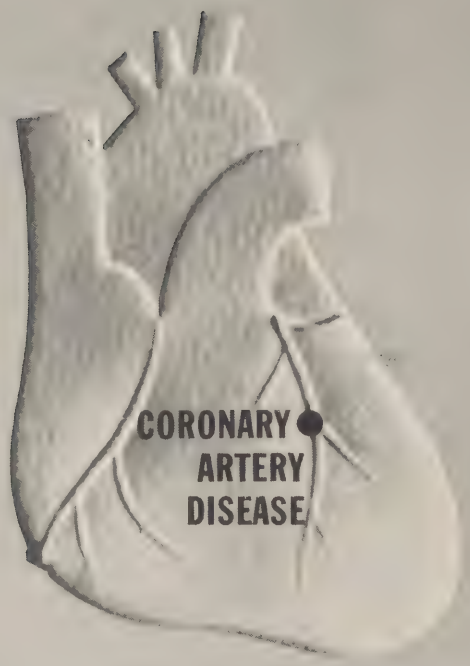
(*Reminder advertisement.* Please see package insert for detailed product information.)

*TRADEMARK, REG. U.S. PAT. OFF.

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KALAMAZOO, MICHIGAN

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● "...now the leading cause of death in diabetic patients."[1]

Diseases of the cardiovascular-renal system account for about three-fourths of deaths among diabetic patients, with heart disease responsible for approximately one-half the total,[2,3] and coronary atherosclerosis the major cause of cardiac lesions.[1] While some feel that diabetics are predisposed, perhaps by heredity, to early onset of vascular disease, considered opinion is that vascular degeneration can be delayed or modified with "...careful and consistent control of diabetes from the time of diagnosis...."[4]

As a major step toward achieving *careful and consistent control,* you can teach your patients to do urine-sugar testing in the way most likely to assure continued cooperation—with the CLINITEST® Urine-Sugar Analysis Set.

for quantitative estimation

color-calibrated

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urine sugar

- continued, close control
- graphic *Analysis Record* encourages co-operation...reveals degree of control at a glance...helps patient maintain control

for "yes-or-no" enzymatic testing

new, improved

clinistix®

urine glucose

10-second reading...longer strip for easier handling...new color chart and color barrier for test area...in glass for protection

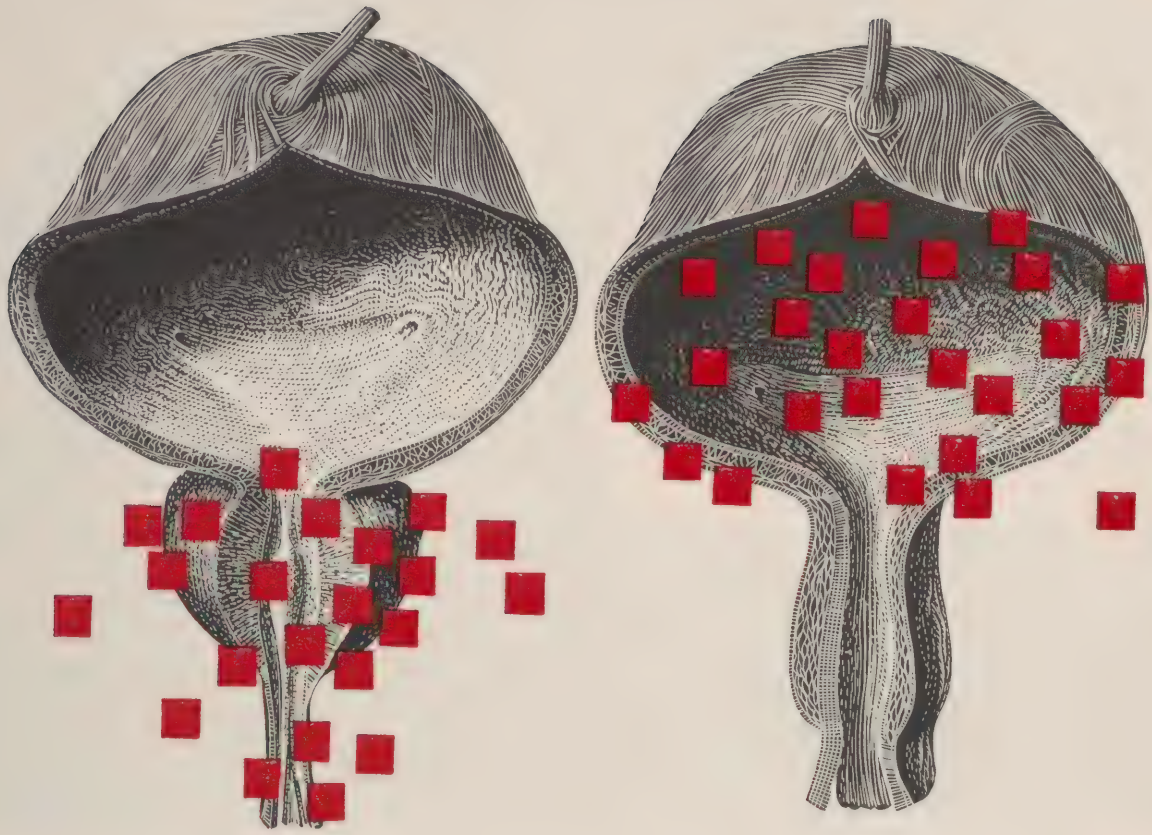
Supplied: CLINITEST Urine-Sugar Analysis Set (with bottle of 36 tablets and 2 foil-wrapped tablets); refill boxes of 24 Sealed-in-Foil Reagent Tablets and bottles of 36 tablets. CLINISTIX Reagent Strips in bottles of 60.

References: (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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Serenium

Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin



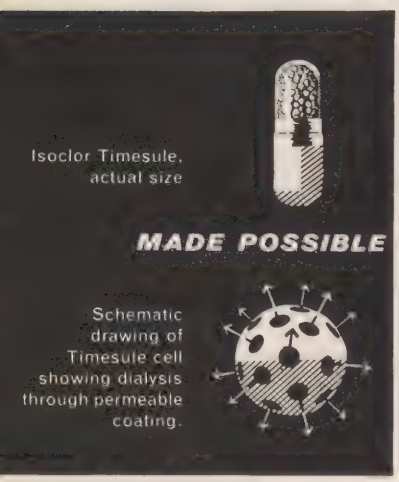
NEW!

Around the clock relief for HAY FEVER DISTRESS

ISOCLOR® TIMESULE®

A NEW COMPREHENSIVE RELIEF

- **Relief usually starts in minutes**—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- **Relief usually lasts up to 12 hours** with a single oral dose
- **Gives both** upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- **With minimal** drowsiness, CNS or pressor stimulation



MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

EACH ISOCLOR TIMESULE CONTAINS:
Chlorpheniramine maleate ..... 10 mg.
d-Isoephedrine HCL ..... 65 mg.
In a special form providing prolonged therapeutic effect.

DOSE: Adults: One Timesule every 12 hours, or as directed.

WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CHARLES C. HASKELL & COMPANY
Richmond, Virginia

DIV ARNAR-STONE LABORATORIES, INC.

For Bronchial Asthma

EACH TABLET CONTAINS	
Aminophylline	2 grains
Ephedrine HCl	¼ grain
Potassium Iodide	3 grains
Phenobarbital	⅓ grain

mùdrane®



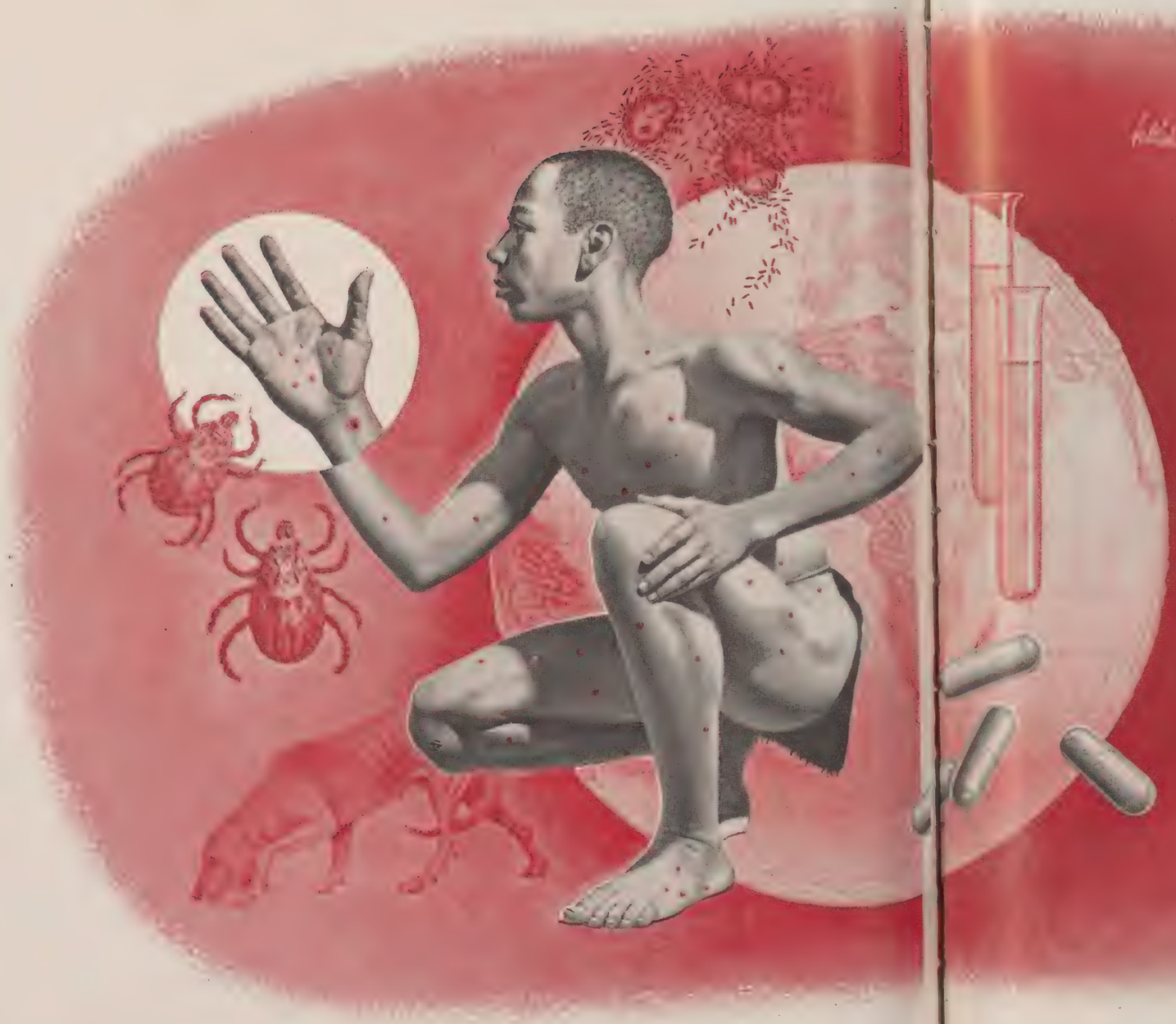
A combination of the most widely recognized drugs for the treatment of asthma . . . . compounded for maximum absorption and balanced action, and buffered for tolerance

Dispensed in bottles of 100 and 1,000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

Science for the world's well-being® Pfizer PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York 17, New York



IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

More detailed professional information available on request.

Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

from boutonneuse fever in Africa to bronchopneumonia in South Carolina

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*

BRAND OF OXYTETRACYCLINE

Terramycin® capsules • syrup • pediatric drops
intramuscular solution • intravenous

also available with nystatin as TERRASTATIN® (capsules and oral suspension)

in respiratory allergies

TRISTACOMP

Orally-administered triple antihistamines plus two effective decongestant agents—to prevent histamine-induced dilatation and exudation of the nasal and paranasal capillaries and to help contract already engorged capillaries, providing welcome relief from rhinorrhea, stuffy noses, sneezing and sinusitis.

2 convenient dosage forms



TRISTACOMP TABLETS

Each sustained release tablet:

Chlorpheniramine Maleate	2.5 mg.
Phenyltoloxamine Citrate	12.5 mg.
Pyrilamine Maleate	25.0 mg.
Phenylephrine Hydrochloride	10.0 mg.
Phenylpropanolamine Hydrochloride	30.0 mg.

Dosage: One tablet morning and night

TRISTACOMP LIQUID

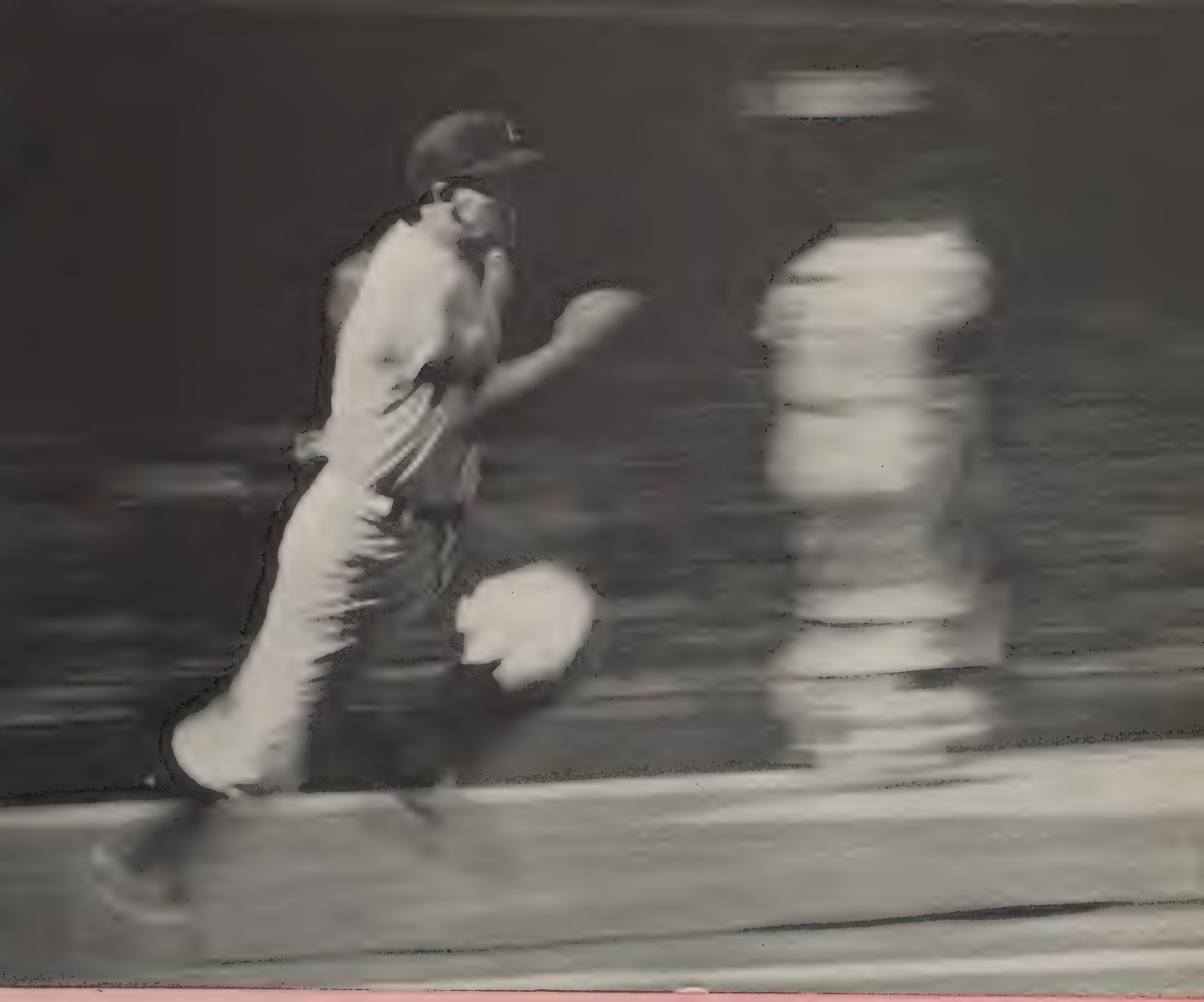
Each 5 cc teaspoonful provides one-fourth the above formula.

Dosage: Adults, two teaspoonfuls three to four times daily. Children, one-half to two teaspoonfuls, according to age.



Samples and literature gladly sent upon request!

PHYSICIANS PRODUCTS CO., INC.
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PERCODAN BRINGS *SPEED*...DURATION... AND DEPTH TO ORAL ANALGESIA

in the wide middle region of pain

PERCODAN

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) TABLETS

fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

Literature on request

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768



CONTINUOUS

PROTECTION IN

ANGINA PECTORIS

ANTORA...

PROVIDES 10 - 12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

ANTORA-B...

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate plus 50 mg. Secobarituric Acid. Medication is released over 10 to 12 hours with fewer side effects and less "hangover" than the longer acting barbiturates. As with Antora, capsules are administered only twice daily instead of the usual 8 to 12 tablets. Administer with caution in glaucoma.

REFER TO PDR

PAGE 643

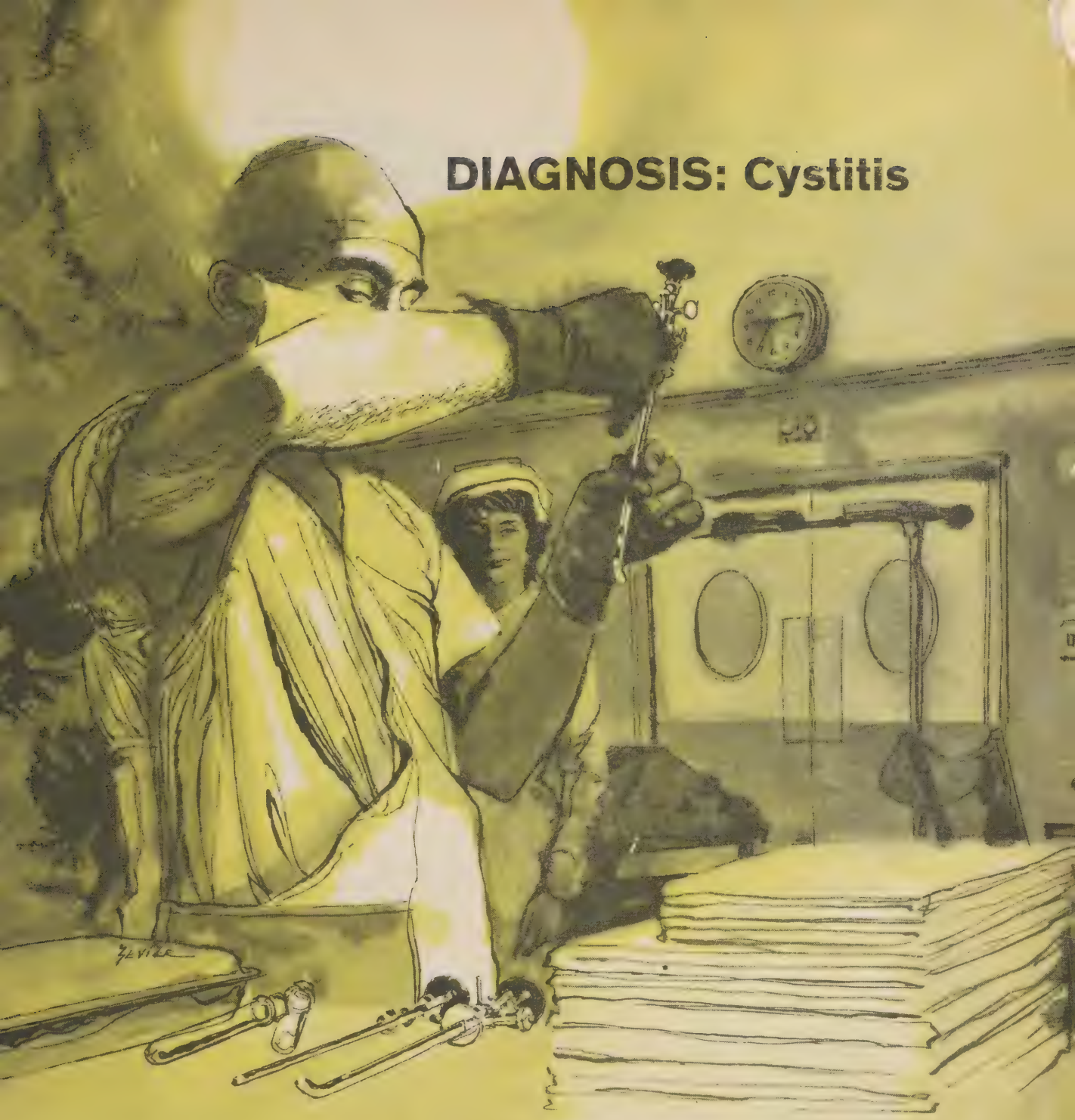
Supplied: Bottles of 60 and 250. Literature and clinical samples available.

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GREENSBORO, NORTH CAROLINA



THERAPEUTIC NEED: Suppression of the bacteriuria.

ANTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

because it provides effective antibacterial activity in the urinary tract.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

PHYSICIAN'S DISABILITY INCOME

APPROVED
FOR MEMBERS OF
THE SOUTH CAROLINA MEDICAL ASSOCIATION

SICKNESS OR ACCIDENT
(MONTHLY BENEFITS)
For total disability from accident:
MONTHLY BENEFIT FOR LIFE--$300.00
For total disability from sickness:
MONTHLY BENEFIT first
12 months ----------$300.00
—thereafter—
NON-CONFINING FOR LIFE -----$150.00
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*Schwartz, I. R..
Current Therap. Res. 3:29, Feb., 1961.

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REFERENCES: (1) Roseman, E.: *Neurology* **11**:912, 1961. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: *M. Clin. North America* **42**:317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) *Ibid.*: *Postgrad. Med.* **20**:584, 1956. (7) Merritt, H. H.: *Brit. M. J.* **1**:666, 1958. (8) Carter, C. H.: *Arch. Neurol. & Psychiat.* **79**:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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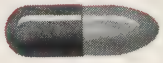
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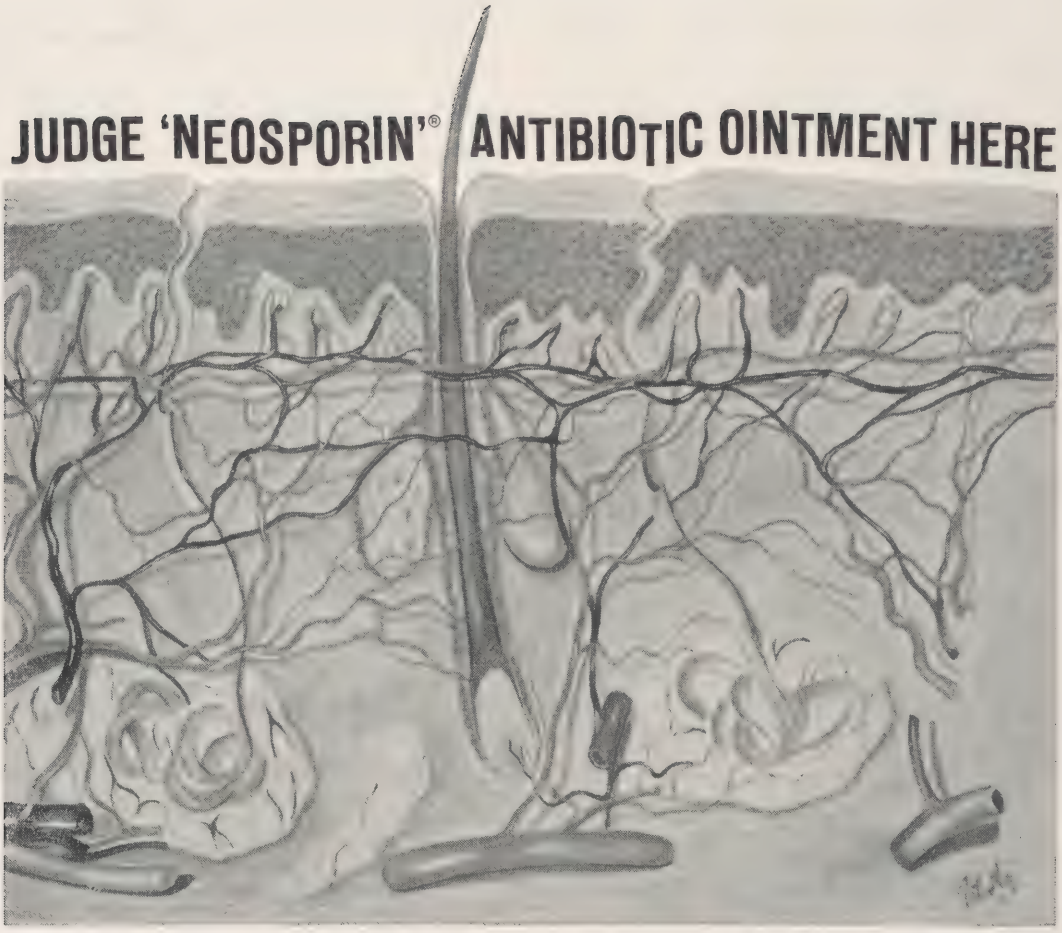
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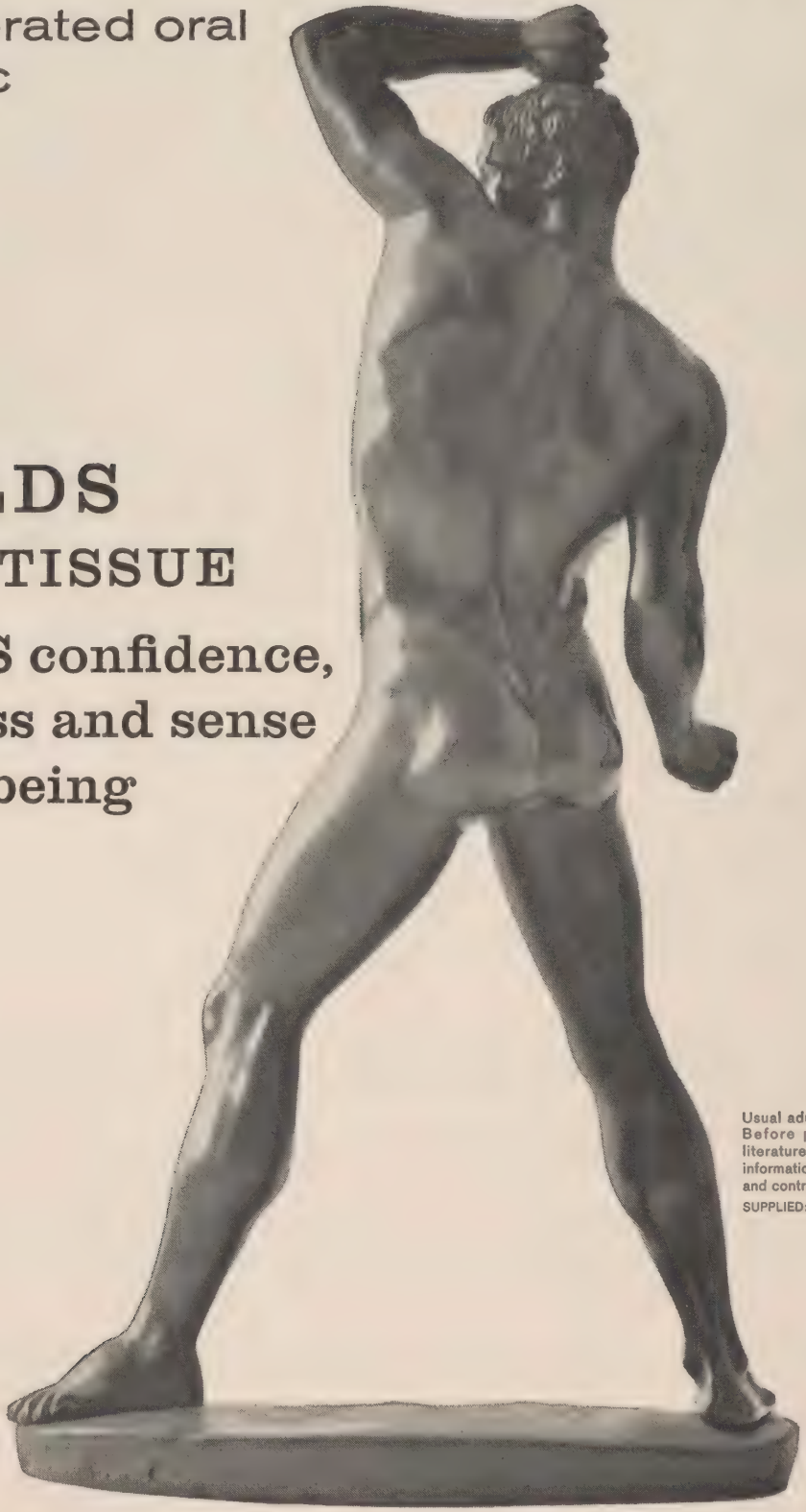
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OCTOBER, 1962 — VOL. 58, NO. 10

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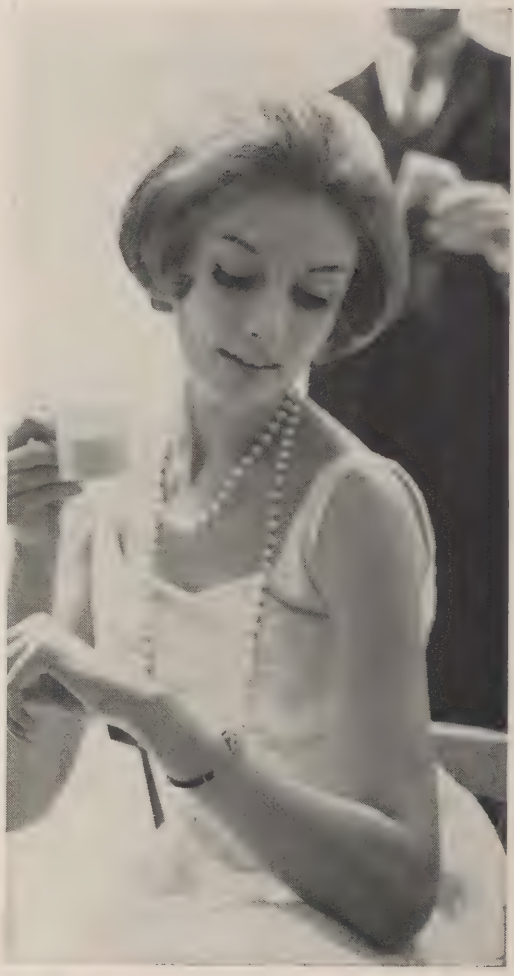
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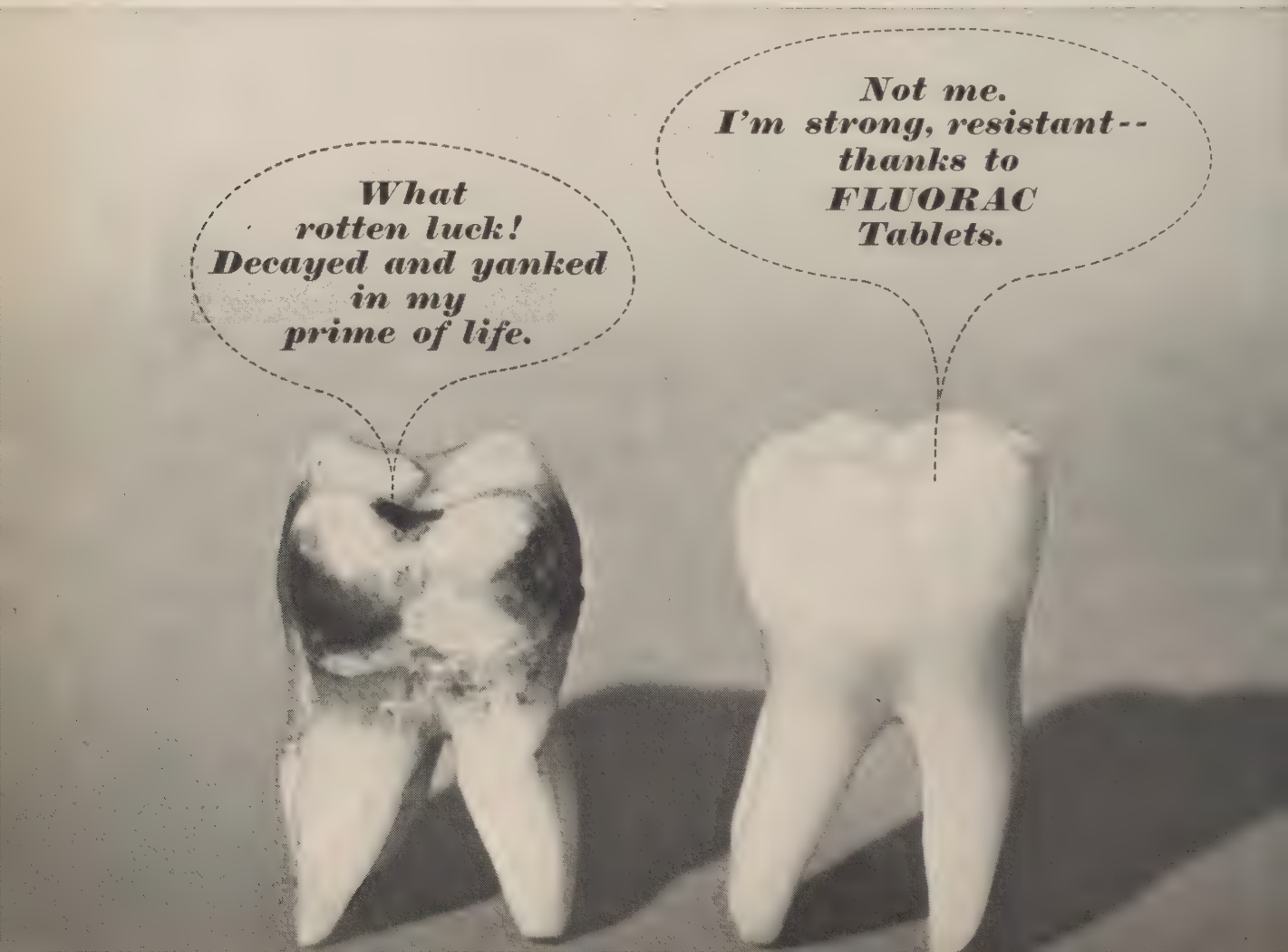
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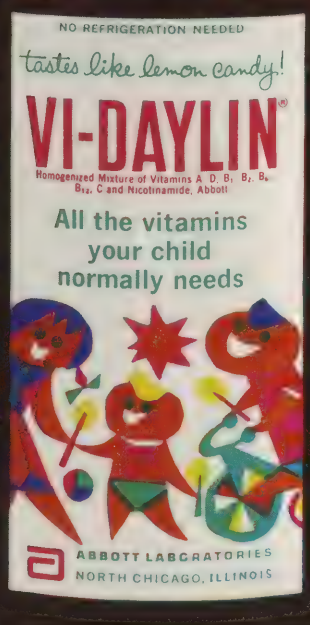
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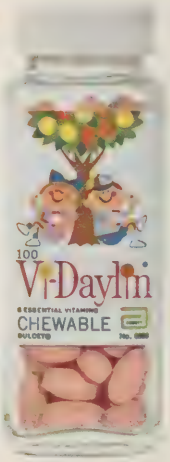
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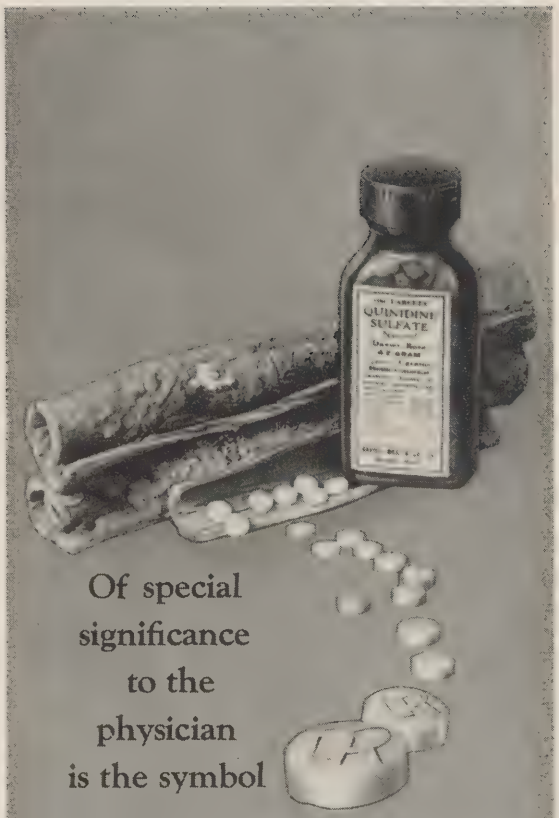
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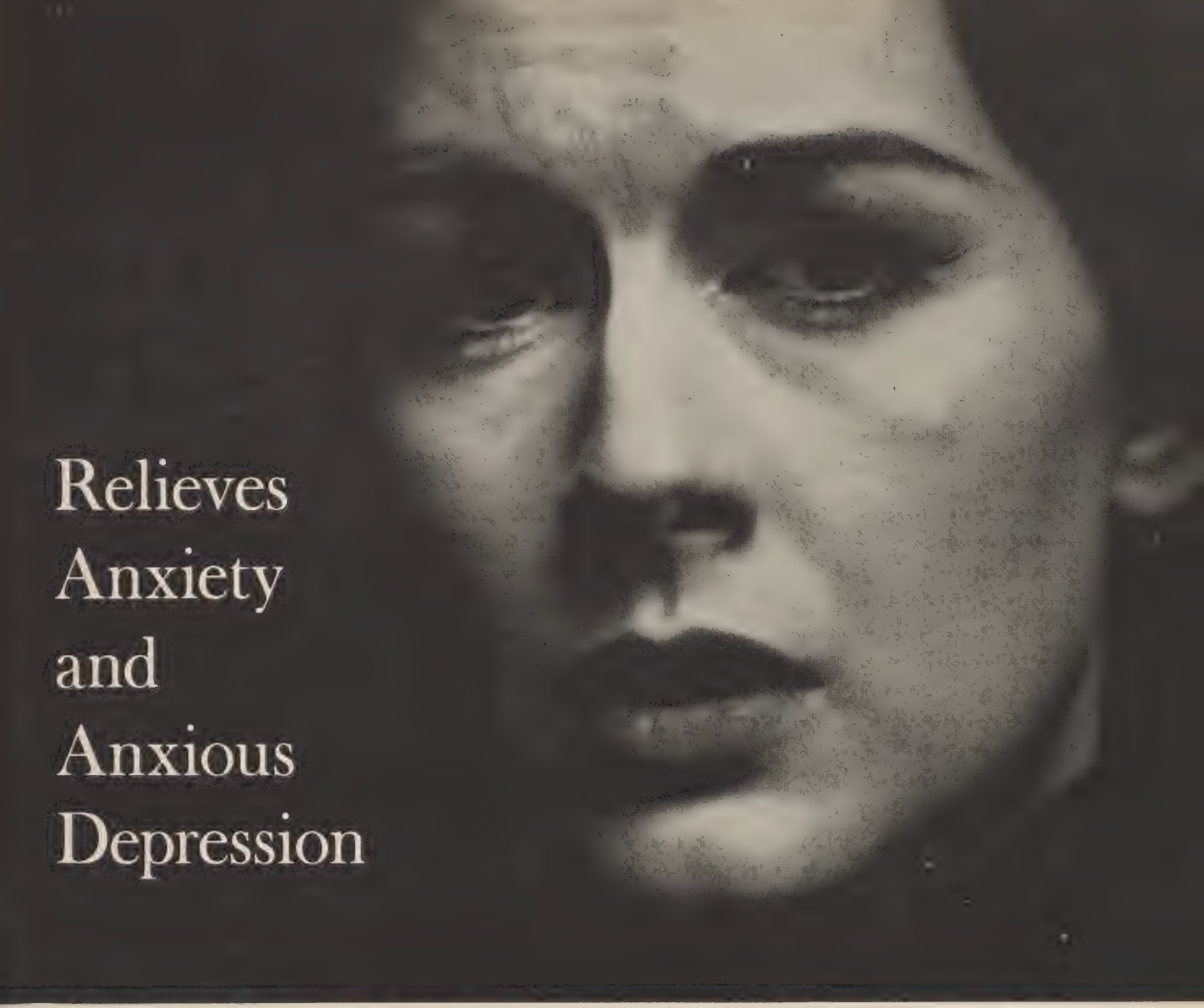
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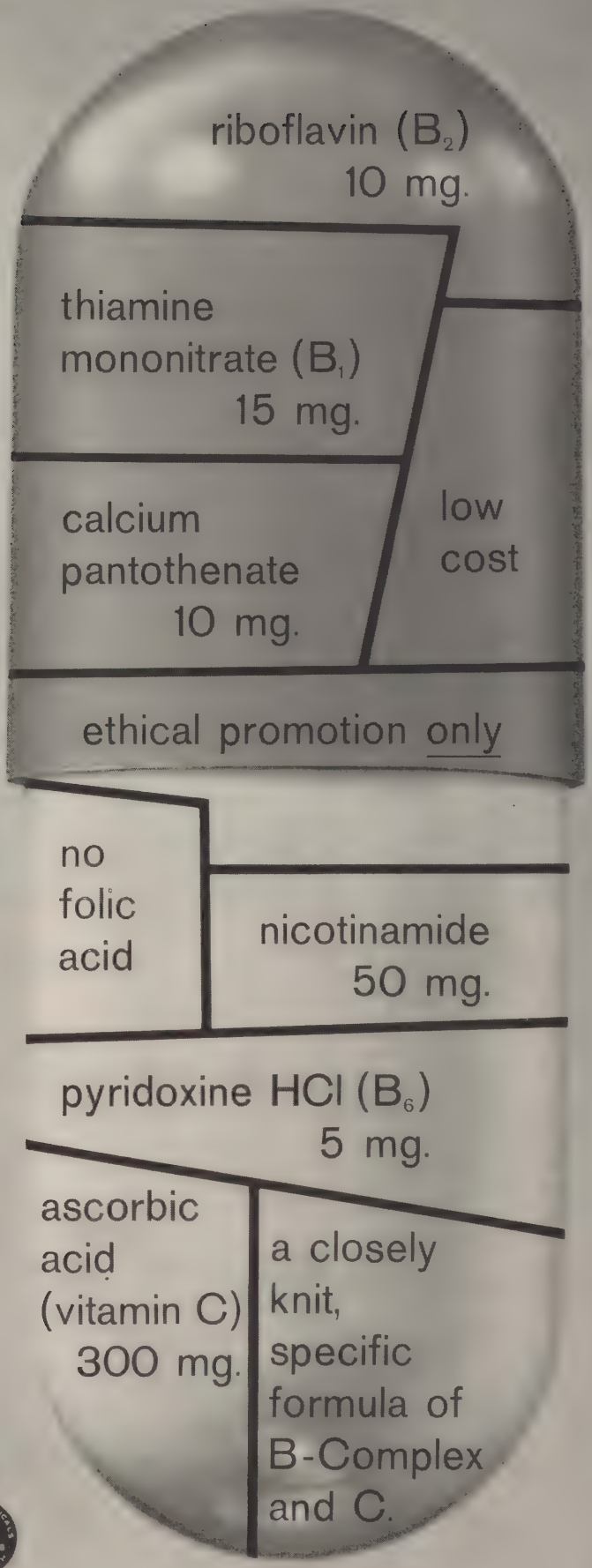
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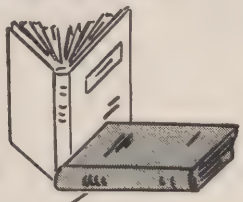
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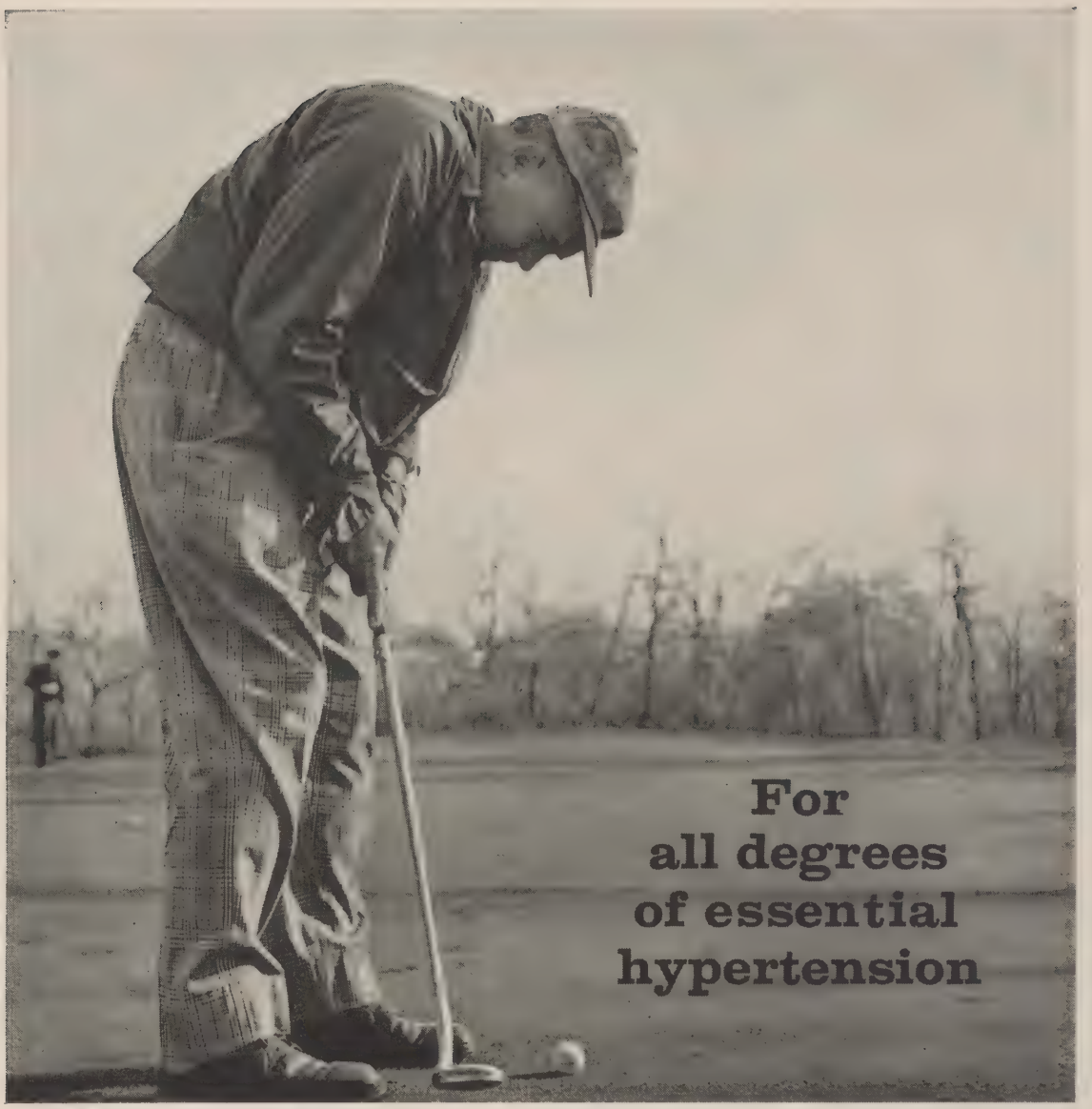
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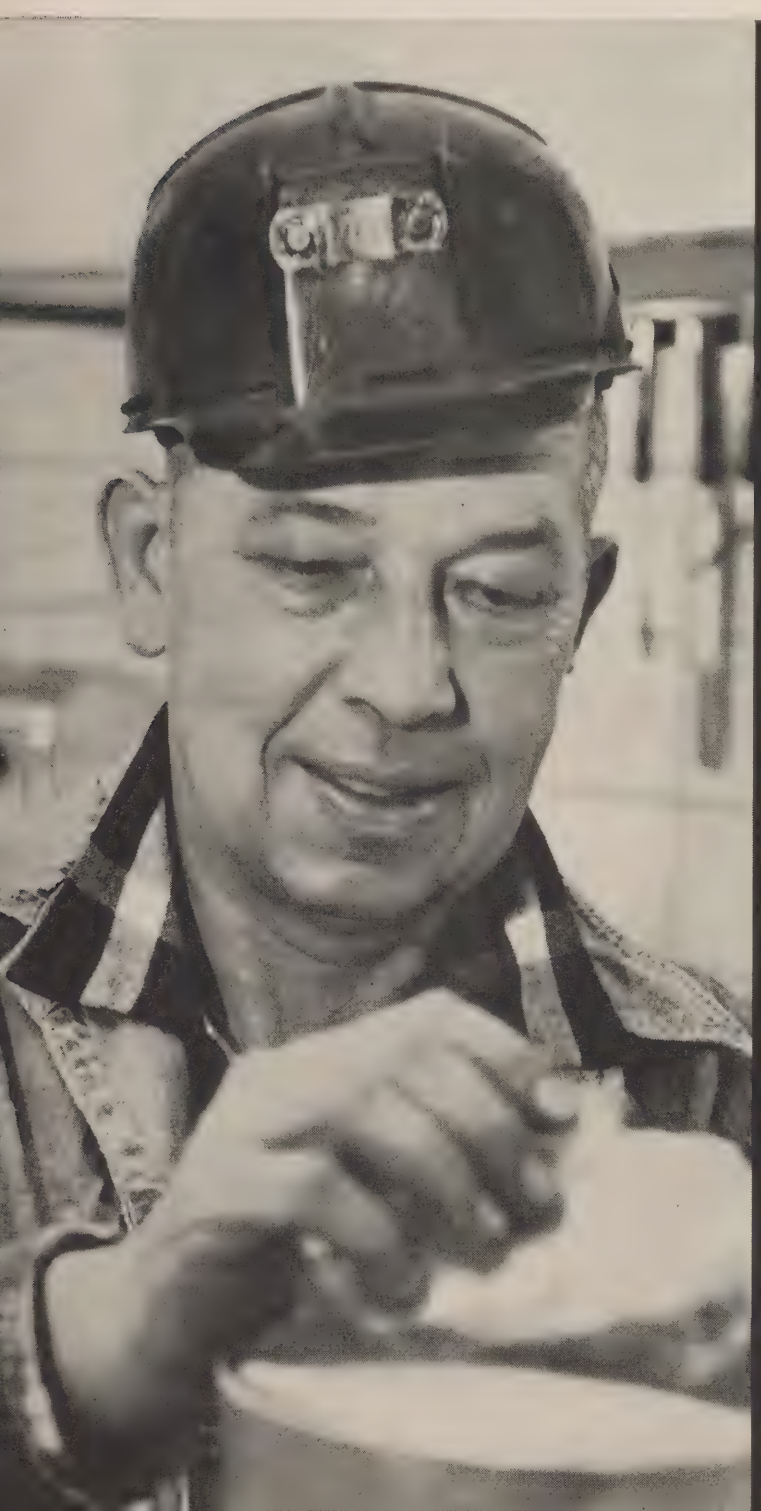
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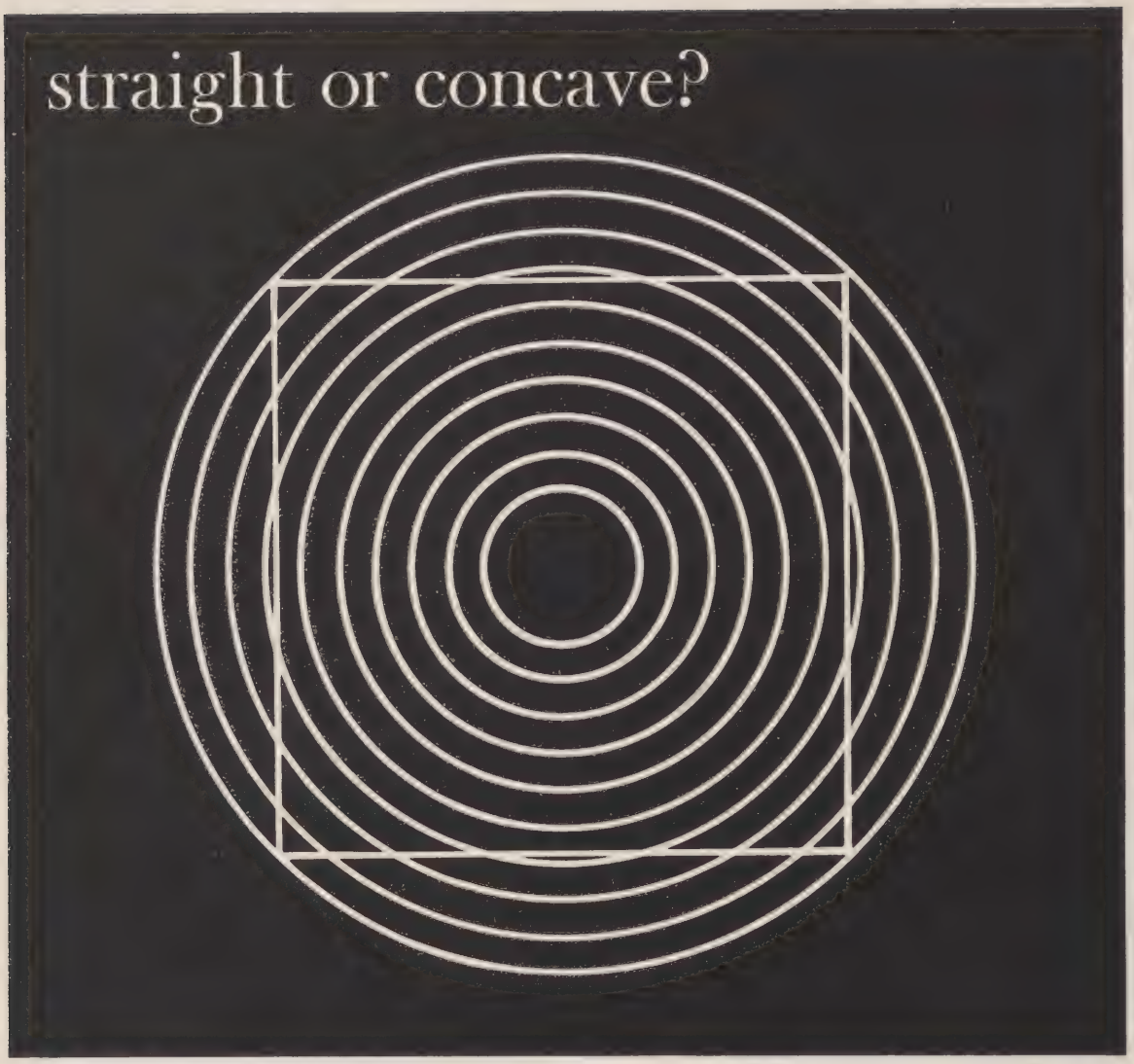


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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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The Journal
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VOLUME 58 October, 1962 NUMBER 10

EXPERIENCE WITH THE COUNTY-WIDE USE OF ORAL POLIO VACCINE TYPE III DURING AN EPIDEMIC

C. A. DUFFORD, M. D.
VON A. LONG, M. D.
Newberry, S. C.

The incidence of poliomyelitis in Newberry County in 1961 exceeded all previous experience with this disease in this county. The purpose of this report is to describe the evolution of the problem, the steps that were taken to meet it, and our experience with the use of the oral polio vaccine during the period when cases were occurring. A later report will deal with our experience and results with oral polio vaccine feeding without the impetus of an epidemic.

Newberry County is located in central South Carolina and is largely rural with a population of 29,641. The City of Newberry with a population of 8,200 is the largest town in the county. Dairying, lumbering and textiles are the chief industries.

Cases of poliomyelitis occurred in Newberry County over a five month period. The first five cases were scattered both in time and location during June, July and August. No epidemiologic connection could be established, and their origin was from various places in the southern part of the county. From August 5 until September 2, 1961, no poliomyelitis or similar illness was noted. From September 2, 1961 through October 23, 1961, nineteen cases of poliomyelitis occurred, eighteen occurring in residents of the county, and one in a resident of Georgia who had a clear epidemiologic connection with the Newberry County outbreak.

The scattered cases which occurred during the first part of the summer created some concern, and an attempt was made early to increase the community immunization level by urging that each citizen obtain Salk vaccine. This was carried out by the usual methods and response to this routine type of appeal was not extraordinary. Motivation for effort to obtain poliomyelitis immunization was not increased by the fear of an epidemic. Extra effort to reduce this public complacency seemed uncalled for since the last paralytic case before the September-October outbreak was in July. Indeed the two August cases were considered as aseptic meningitis until recovery of Type III poliomyelitis virus was made from stool specimens.

The outbreak of poliomyelitis which occurred in September and October was a sharp experience with a high attack rate and represented an epidemiologic entity with all but three cases occurring in Negroes and with all

but three cases epidemiologically traceable to the one Negro elementary school in the City of Newberry. The pattern which this outbreak followed is interesting, from a number of points, not the least of which is the age distribution of cases and the race involved, both atypical for previous experience in South Carolina.

The problem as it evolved was met by usual public health measures. Actual case recognition was usually delayed until hospitalization, and in a few cases until recovery of virus by the laboratory. The chart below shows the cases by date of onset.

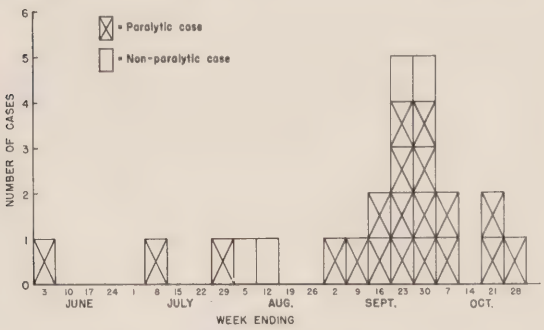


Chart I—Poliomyelitis Cases in Newberry County, 1961 by Date of Onset.

Early consideration was given as to means of curtailing the Fall outbreak. The possibility of the use of oral vaccine was entertained as early as September 10, 1961. The classification of the early cases as type III poliomyelitis made the community ineligible to receive oral vaccine from the Epidemic Reserve of types I and II vaccine of the United States Public Health Service. There was no knowledge of the availability of unlicensed type III vaccine. The season of the year and the many atypical features of the outbreak in terms of previous South Carolina experience caused us to think that possibly there might be an early termination of the outbreak, a forecast which proved unrealistic.

Response to vaccination efforts with inactivated (Salk type) vaccine increased markedly as more and more community motivation was supplied with each new case. Over 6,000 doses of Salk vaccine were given in September 1961 as compared to only 2,000 doses in September 1960.

The several sharp increases in rate of administration could be correlated to increased motivation such as the death of a patient on September 26, 1961. To this point the white population of the community was spared from the effects of this virus and their anxiety and response was minimal.

With the continuing occurrence of cases and the realization that an atypical and serious situation was taking place, a re-evaluation of preventive measures was made. It seemed propitious that a more complete evaluation of the outbreak be made, and more thought be given to the use of either type specific or heterotypic oral polio virus vaccine in terminating the outbreak. Conferences with officials of the State Board of Health regarding the possibility of securing oral vaccine were held and the United States Public Health Service was asked for their assistance in procuring the oral vaccine and epidemiologic assistance.

With the delineation of the epidemiology it became clear:

(a) That the group involved was chiefly elementary school age Negro children.

(b) That the immunization level of the Negro community (below the high school) was lacking despite the amount of inactivated vaccine distributed during the previous month.

(c) The differences in immunization between the white and Negro communities accounted for the atypical nature of this outbreak of poliomyelitis.

(d) That the presence of the wild virus in the community was a fact which threatened the entire community and could best be dealt with by using the oral polio virus vaccine, both for immediate blocking effect and in supplying type specific antibody to those lacking.

To this end arrangement was made with Dr.

Albert Sabin to use the remaining portion of his supply of type III oral vaccine, and he kindly supplied 25,000 doses.

The mechanics of publicity, distribution and administration were carried out as follows:

(a) It was felt that unanimous acceptance and recommendation of the use of this vaccine by the physicians of the county would be the chief factor in public acceptance and in enlisting community backing. This was obtained early in a written form and publicised.

(b) It was decided to use the vaccine, and publicity surrounding its availability was released one week before administration. From this moment, the ordinary news media of the regional and local papers, the regional television stations and the local radio station gave full publicity to the effort and informed the public in repeated announcements as means of distribution were decided upon.

(c) Because the outbreak had manifested itself chiefly in the Negro community the virus was probably most common in that segment of the population. This community was also lacking in immunization by the inactivated vaccine as revealed by a random household survey in Newberry city. A special effort was therefore made to reach these people. The Negro ministers and the local undertaker who had a very popular radio pragrom were enlisted in obtaining this goal.

(d) Vaccine distribution through the schools and at the schools was deemed the best method of getting optimal county-wide coverage. Schools within the town and through the county were chosen for geographic location. Distribution to the schools where there was no permanent vaccination station was made from nearby schools. The estimated dose of vaccine needed at each station was determined by multiplying the school population served by three. This proved largely adequate with the drawbacks noted below. The distribution was planned for one day, October 19, 1961, with a make-up period set for the following night at the county health department for those unable to come. Ten vaccination stations were designated—three within the city of Newberry and seven at schools through the county. These stations were manned by the private physicians of the county, nurses, and clerical workers, all of whom were voluntary, and by the staff of the county health department.

(e) It was planned that a buffer supply be held at the county health department to be taken to stations where the supply ran low. Arrangements were made with the local funeral directors to provide coordinating transportation for the vaccination campaign.

(f) Many groups in the county participated in the publicity and operation of the clinics. Chain telephone conversations by ladies in Mother's Clubs, the County Medical Auxiliary, PTA's and men's civic clubs helped disseminate information about the vaccine and clinic locations throughout the county. The ministers of the various churches made announcements in their respective churches regarding the vaccine campaign. The physicians of the county provided the medical staff for the clinics, the county hospital nurses alumni association and the county nurses association provided the nurses and medical auxiliary and other ladies organizations provided the clerical staff. The Department of Education made the school buses available for transportation of rural patrons which was especially beneficial to the colored population. Farmers, presidents and managers of industrial and commercial plants arranged for their tenants and employees to get to one of the vaccine stations. The campaign was truly a total community effort.

(g) A vaccination card was obtained as a

record for each vaccinee. The school children were pre-registered. The parents of school children were given the option of refusing the vaccination for their children. Only 3 of 7,000 took this recourse.

The actual vaccine administration was remarkably smooth and uneventful except for the fact that within two hours of the opening of the feeding station the immediate supply of vaccine was exhausted. The population turnout was extraordinary, perhaps excessively spurred by the occurrence of poliomyelitis in a 32 year old white male on the evening before the vaccine administration. The reserve supplies were obtained and distributed and the vaccine stations reopened for two hours in the afternoon. The afternoon vaccination was limited to those under forty years of age. Enough vaccine remained for the scheduled night clinic on October 20, and by the end of the program each presenting vaccinee had been served (though some had to present themselves several times in order to achieve this). All of the vaccine was used.

Following the vaccination effort, the vaccination records were sorted as to race (white and non-white) and age group under forty. The total was counted and the following statistics were obtained:

Table I—Estimated Population and Number of Individuals Under Forty Years of Age Given Oral Polio Vaccine Type III, Newberry County, October 1961.

Population Total		Est. Population Under 40 yrs.		No. Vac'd. Under 40 yrs.		% Vac'd. Under 40 yrs.	
W	NW	W	NW	W	NW	W	NW
18,982	10,434	11,094	7,402	10,196	6,491	91	89

The problem of non-residents utilizing the vaccine was felt to be insignificant in that the estimated vaccine utilization at "border" stations did not go above that expected.

Following the use of the vaccine, only one case of clinical poliomyelitis was recognized. This seven year old Negro child had the onset of her illness three days after receiving the oral vaccine. This case is not considered vaccine associated.

Whether there was a real effect on the course of the outbreak or not is questionable. There is no doubt but that the immune level of both the White and Negro communities against type III poliomyelitis was enhanced.

Conclusions and Summary

An outbreak of type III poliomyelitis involving chiefly the Negro grade school population of Newberry County occurred in 1961. The extraordinary incidence and the population involved led to our electing to use type III oral polio virus vaccine (an unlicensed vaccine donated by Dr. Albert Sabin) in the entire community. The white populace was identified with the outbreak by the occurrence of the disease (ultimately fatal) in an adult white male and a 2 year old female.

All publicity media were used to acquaint the public with the vaccine and the plans for its distribution. The entire community was enlisted in the vaccination effort, and the unqualified backing of the physicians of the county was felt to play a large role in the acceptance of the vaccine.

A "blitz" type program was devised with a one-day distribution from stations at the schools. The response was rapid and almost overwhelming. Ninety percent of the population under 40 years of age was vaccinated. There were no cases of vaccine-associated cases of poliomyelitis.

Two concentrated programs of a similar type were carried out on February 8, 1962 when Type I oral polio vaccine was administered and again on March 29, 1962 with Type II. The response to both these programs was remarkable, a total of 21,750 doses of Type I and 20,483 of Type II being administered.

We wish to thank Dr. James A. Bryan, II of the U. S. Public Health Service and Dr. G. E. McDaniel of the S. C. State Board of Health for their advice and assistance in the preparation of this paper.

DETERMINATION ON POLIOMYELITIS ANTIBODY TITERS FROM ROUTINE IMMUNIZATIONS

MARGARET Q. JENKINS, M. D.
Medical College of South Carolina

The principle of protecting infants and young children against disease by the use of active immunization has been well established in the past as an effective means of reducing morbidity and mortality from diseases caused by bacteria, specifically diphtheria, pertussis and tetanus. With the advances in recent years in the field of virology active immunization against poliomyelitis has now become possible and it is anticipated that, in the near future, protection may be afforded against other equally serious diseases of a viral nature. It is important that immunizations not only give protection, and are safe, but they must also be given at an appropriate age to assure protection at the time of natural exposure to the disease. In evaluating any new vaccine it is therefore important to keep the above factors in mind in determining the dose necessary, the time interval between immunizing injections, possible antagonism from naturally occurring antibodies, and the immunilogic maturity of the patient. This study is, therefore, an attempt to evaluate the effectiveness of poliomyelitis vaccine in combination with diphtheria, pertussis and tetanus vaccines.

In a series of articles on combined immunization against diphtheria, tetanus and pertussis in newborn infants by diSant'Agnese[1] several important factors were presented which must be taken into consideration in the problem of routine immunization with poliomyelitis vaccine. Laboratory studies such as serum antibody and antitoxin levels give a measure of the amount of protection against infection, but the actual response of the patient to a clinical exposure of the disease is a more accurate measure of effectiveness of immunizations. For some diseases such as diphtheria and tetanus the antitoxin level in the blood and clinical immunity appear quite closely related, but this is less true of pertussis.

It has been found that about 60% of newborn infants have adequate protective levels of antibodies to diphtheria but that there is essentially no pertussis or tetanus antibody present at birth. It has also been found that the response after the initial series of three immunizations against diphtheria, tetanus, and pertussis is excellent against tetanus, and is generally very good against diphtheria, although in the newborns with a moderately high pre-immunization titer a significantly lower titer (by one half) against diphtheria is obtained. The pertussis vaccine is not as highly antigenic as that of tetanus and diphtheria and a protective titer occurs in only about 50% of infants after the initial series of three injections, and only about 60% after the booster injection at one year. It has also been found that combining the diphtheria, tetanus and pertussis antigens in an alum precipitated solution actually gave better titers than did the vaccines given separately.[2]

The proven effectiveness of the Salk poliomyelitis vaccine in causing a rise in antibody titers and in protection against the disease has been well documented following the field trials of poliomyelitis in 1954 as summarized by Francis[3] and since then by many other studies.[4, 5, 6, 7] The safety of this vaccine has also been proved. The actual serum antibody titers have varied with vaccine potency. Again, as with diphtheria, the problem of passive antibodies interfering with the production of active immunity when the maternal antibody titer is high and giving a poorer response to

immunization with the polio vaccine is noted.[7] The youngest age at which routine immunizations against poliomyelitis can generally be expected to give good results has not been definitely established.

An additional factor is the concern about antibody levels to the three types of polio vaccine. If the patient has natural immunity to Type I virus, he is also found to have some antigenic components to Type II virus but relatively none for Type III. Type II virus, however, produces significant antigenic components for both Type I and Type III, while Type III, which is least pathogenic, produces practically no Type I antigen but a moderate amount of Type II antigen. Type I virus is the most important clinically since it causes paralytic disease more frequently than Type II or III.[5]

Combining the routine immunizations into as few injections as possible is obviously desirable. First, from the psychological standpoint, second from the number of return visits necessary to complete the series, third from the standpoint of possible antagonism from the various antigens in a combined vaccine and fourth from the standpoint of possible side effects. Studies using the combined diphtheria, tetanus, pertussis, polio vaccine[8, 9] have shown that there is no reduction in diphtheria and pertussis antibody response in the combined quadruple vaccine since this response is actually greater than with the triple vaccine. Batson *et al*[9] found that there was an insignificant poliomyelitis titer rise after the primary series but that booster shots gave good titers in the 100 patients included in the study.

The problem of the immune mechanism being immature in newborn infants and thereby requiring a high antigenic stimulus to effect immunization must also be taken into consideration. In addition, the transplacental transfer of maternal antibodies against poliomyelitis and their time of disappearance from the young infant is an important factor in poliomyelitis immunizations. Da Silva, *et al*[7] showed that the infant's poliomyelitis antibody levels were essentially the same as the mother's when done on cord blood, and that 50% of the passively transferred antibodies were eliminated in five weeks and that the passive antibody was retained for a period related to the titer at birth. He also showed that the infants' response to poliomyelitis immunizations were poorer than the mothers' when given at one year of age or younger.

II. Method

The first part of this study was an effort to determine the side effects and immunological response to combined DPT-Salk polio vaccines (quadruple vaccine) as compared with DPT (triple vaccine) and polio vaccines given separately. The quadruple vaccine used in this study was the new 0.5 ml. dose Tetravax (Merck, Sharp & Dohme).

Infants without previous immunizations attending the Well Baby Clinic of the Medical College of South Carolina were alternately placed in one of two groups for the vaccine study. Infants in Group I received DPT (triple vaccine) and Salk polio vaccine in separate injections, and infants in Group II received combined DPT-polio vaccine (quadruple vaccine). Infants from 2-12 months of age without previous immunizations were given 3 monthly injections of vaccine as recommended by the American Academy of Pediatrics Committee on Infectious Diseases. Serum antibody titers against poliomyelitis were determined at the beginning and again one month after completion of the series of immunizations.

In this study 233 infants were included and 156 of these completed the series of 3 injections and had blood drawn for pre- and post-immunization series titers. A few blood samples were unsatisfactory so that there were 76 patients in Group I (DPT-Polio) and 72 patients in Group II (quadruple vaccine). The serum antibody determinations were determined by the metabolic inhibition tests for neutralizing antibodies.* Approximately two

*By Merck, Sharpe & Dohme Laboratories

thirds of the patients were 2 months of age at the beginning of their immunizations and less than 70% showed some rise in antibody titers one month after completion of the series of

three injections. Approximately one fourth of the patients were 3 to 6 months of age at the beginning of the study and 75% showed some rise in titer. (Table I). In those over 6 months of age there were 9 in Group I and 4 in Group II with some rise in titer present in 100% of the patients. No statistically significant differences were found between the preparations with regard to either conversion response rate or geometric mean titer.

Since the protection against poliomyelitis from the 3 injections given in the initial series was not optimum, further study was indicated to determine a satisfactory plan for routine immunization of infants. Subsequently pre- and post-booster titer determinations against

TABLE I
First Series

AGE	GROUP I Polio & DPT Number of Patients Injected	Percent Showing Rise Type I	Type II	Type III	GROUP II Tetravax Number of Patients Injected	Percent Showing Rise Type I	Type II	Type III
Up to 3 months	51	33.3%	35.3%	56.8%	44	18.1%	29.5%	52.2%
3 to 6 months	16	43.7%	50%	62.5%	24	37.5%	62.5%	79.1%
6 months and over	9	77.7%	88.8%	100%	4	75%	100%	100%
TOTALS	76	40.7%	44.7%	63.1%	72	27.7%	44.4%	63.8%

TABLE II
Booster Series
Group I
Polio & DPT

AGE	One Month Between Shots No. Pts. Inj.	Percent Showing Rise Type I	Type II	Type III	Over 1 Month Between Shots No. Pts. Inj.	Percent Showing Rise Type I	Type II	Type III
Up to 3 months	20	85%	100%	95%	10	90%	100%	90%
3 months to 6 months	7	100%	85.7%	85.7%	8	37.5%	75%	75%
6 months and over	--	--	--	--	1	100%	100%	0%
TOTALS	27	88.8%	96.2%	95.1%	19	68.4%	89.4%	78.9%

Group II
Tetravax

AGE	One Month Between Shots No. Pts. Inj.	Percent Showing Rise Type I	Type II	Type III	Over 1 Month Between Shots No. Pts. Inj.	Percent Showing Rise Type I	Type II	Type III
Up to 3 months	18	72.2%	94.4%	94.4%	15	60%	80%	80%
3 months to 6 months	7	42.8%	57.1%	57.1%	6	66.6%	83.3%	83.3%
6 months and over	1	100%	0%	0%	2	100%	100%	100%
TOTALS	26	65.3%	80.7%	80.7%	23	65.2%	82.6%	82.6%

poliomyelitis were obtained six to twelve months after the last injection. Ninety-five patients of the 156 who completed the initial study returned for the booster study. Fifty-three of these had post-booster blood drawn at one month after the booster injections. Of those 27 were in Group I (DPT-polio) and 26 in Group II (quadruple vaccine). Some rise in antibody titer was seen in 93% of the patients in Group I and 96% of patients in Group II, with Type I showing the poorest response in both groups. (Table II)

III Discussion

From the above results it will be noted that while an antibody titer rise in the majority of infants one month after the initial series of three immunizations begun at 2 months of age was present in less than 70%, a titer rise one month following the booster injections was noted in 94.5% of the patients. No difference was noted in the group who received the quadruple vaccine as compared to those receiving the same dose with poliomyelitis vaccine given as a separate injection. No significant side effects were reported by the parents of the children in this study and therefore it may be concluded that a combined diphtheria, pertussis, tetanus, polio vaccine is acceptable from the standpoint of safety and protection.

The optimum age for beginning the immunization has not been completely resolved by this study. The desirability of protecting the very young infants against pertussis has been the prime reason for recommending routine immunizations in the first few months of life. Since immunization against diphtheria and tetanus is also highly desirable and, in order to reduce the total number of injections required to obtain this immunized status, the routine practice has been to give DPT immunizations beginning at about two to three months of age. This has generally been accepted in spite of the known interference by maternal antibodies to the developing of active antibodies to diphtheria. However, since a booster injection at one year of age gives consistently good titers against all three antigens, the protection against diphtheria following the initial series has not been considered a contraindication to this plan. It would appear from the above study that the same factors are present regarding poliomyelitis vaccine. Certainly young infants are frequently reported to have developed the paralytic disease and while the incidence is not great under one year, a rather abrupt rise in the incidence above this age has been reported.[10] The above plan of beginning routine immunizations at two months and using a quadruple vaccine for diphtheria, pertussis, tetanus and polio with a booster at ten months would give adequate protection for all four of these diseases at one year. Since other studies have shown[7, 10] that passively transferred poliomyelitis antibodies are absent or present in very low titers by six months of age, antibodies which remain after this time, as in the pre-booster titers obtained at ten months of age or older should signify active antibodies produced by the infant. It also appears from this study that the infant is sensitized by the initial series, and therefore responds with an adequate titer following the booster injection, even though his post-series titers were not considered adequate. An alternative plan would be to give the DPT immunizations and to follow with the polio immunizations after six months of age since a better titer is obtained following this plan. However, the booster injection would thereby be delayed until 13 to 15 months of age and the plan has other disadvantages such as more frequent return visits, more psychogenic trauma to the child, etc., the former being particularly serious from a public health standpoint.

Summary

A study was conducted in the outpatient clinic to evaluate the relative effectiveness of a quadruple vaccine for diphtheria, tetanus, pertussis and polio as compared to a triple vaccine for diphtheria, pertussis and tetanus and polio vaccine given separately.

One hundred and fifty-six infants from 2 to 12 months were placed in alternate groups and had pre-vaccination and post-vaccination titers determined one month after a series of three monthly injections. Approximately two thirds of the infants were two months of age

at the beginning of the study and less than 70% showed a rise in poliomyelitis antibody titers. One third of the infants were 3-6 months of age and 75% of these showed a rise in titer.

In addition, pre-booster and post-booster titers were determined in 92 of the patients with the booster injection being given 6 to 12 months after the initial series was completed. Sixty-one of these patients returned one month post-booster injection and 95% showed rises in antibody titers.

No significant differences were noted in the two groups receiving different vaccines. No untoward side effects were detected in any patient.

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PEUTZ-JEGHERS SYNDROME

A CASE REPORT

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JOHN F. MOFFETT, M. D.,
N. DOUGLAS ELLIS, M. D.,
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The clinical syndrome of mucocutaneous pigmentation with intestinal polyosis was first described by Peutz[1] in 1921. Little attention was paid to this subject until Jeghers *et al.*[2] reviewed the literature in 1949. Since that time, the Peutz-Jeghers syndrome has become an accepted clinical entity with more than 100 cases reported in the literature. Wenzl *et al.*[3] have recently noted "a striking paucity of reports in the pediatric literature, despite the relatively frequent occurrence of the syndrome in children". It is our purpose to report a case of this syndrome in a child and to familiarize the reader with this entity. Since there seems to be a familial element in this condition, physicians in the Pee Dee section of the Carolinas should be alert to detect others with this syndrome.

Report of A Case

A white male, 7 years and 11 months old, was admitted to the McLeod Infirmary in October, 1961, with a chief complaint of "vomiting spells for the past two and one-half months". The patient had been having intermittent episodes of colicky periumbilical pain for three years. Initially the pain occurred only once every two to three months and was unaccompanied by other symptoms. These episodes increased in frequency and intensity to the point that the patient was experiencing almost daily attacks. For several months he had experienced vomiting after some of the attacks of abdominal pain. Emesis frequently provided relief for from 30 minutes to several hours. The pain varied in duration but seemed to subside spontaneously or immediately after vomiting. No positional changes nor special foods were noted to increase or decrease the severity of the pain or the frequency with which these episodes occurred.

The child was described as a poor eater who had gained little weight in the past years although the mother kept no record of growth. His bowel habits were described as normal with no history of melena or rectal bleeding. The patient had colic during early infancy, this having subsided within the first year of life. Until the present illness there was only an occasional complaint of a "stomach-ache" to which the parents paid little attention.



Quarles Studio

The patient was the product of a normal pregnancy and delivery and weighed 10 pounds, 3 ounces at birth. "Freckle-like" pigmentation of the mucocutaneous junction of the lips was noted at birth. Growth and development in relation to his siblings and playmates seemed normal. The child received DPT immunizations during infancy but has received no polio vaccine. He has had measles and chicken pox but no serious illnesses. There is no family history of

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similar mucocutaneous pigmentation nor episodes of abdominal pain and vomiting.

Physical Findings:

Weight—46½ pounds, Height—48¾ inches. Temperature—99° F., Pulse—88, Respirations—16. Blood pressure—122/80 mm. Hg. The patient was a well-developed, asthenic white male below the 3rd percentile for weight and between the 3rd and 10th percentile for height. He was noted to have freckles but more striking were the prominent "freckle-like" areas of pigmentation at the mucocutaneous junction of the lips. (See Fig. 1) There was a deeper than usual pigmentation to the "freckles" about the nose and cheeks. The buccal mucosa revealed several punctate areas of brownish pigmentation. No other areas of abnormal pigmentation were noted. The abdomen was soft with no evidence of organ enlargement although a questionable mass was palpated in the left lower quadrant. The remainder of the physical examination was non-contributory.

Laboratory Findings:

The blood revealed a hemoglobin concentration of 11 Gm./100 ml. and a leucocyte count of 5,297/mm^3, with a differential of 61 polymorphonuclear leukocytes, 37 lymphocytes, and 1 eosinophil. Urinalysis was normal. Stool examination was positive for occult blood but negative for parasites.

X-ray examination of the upper gastrointestinal tract with barium revealed incomplete intestinal obstructions in the distal duodenum and jejunum. No polyps were demonstrated.

Clinical Course:

In the hospital the patient continued to have episodes of abdominal pain only partially relieved by codeine intramuscularly. These episodes became more severe and were associated with vomiting, prostration, and weight loss requiring large amounts of intravenous fluids. When it became our impression that the patient had the Peutz-Jeghers syndrome and was experiencing episodes of intermittent intussusception with spontaneous reductions, an exploratory laparotomy was performed on the fifth hospital day. A jejuno-jejunal intussusception was found and reduced manually. Two jejunal polyps were removed through an enterostomy, and the remainder of the small bowel was explored through enterostomies with the use of a sigmoidoscope. No other polyps were found.

The polyps removed appeared as two irregular, roughly oval lobulated masses, the larger 3.8 cm. in its greatest dimension. The tissue was pinkish-gray and soft. Sections of the lesion revealed a polypoid roughening of the surface with an intact mucosa. The epithelial cells varied moderately in size, the majority being of a tall columnar type and forming a papillary and glandular pattern with some thickening of the mucosa. The basement membrane was intact throughout multiple sections with no evidence of malignancy.

The postoperative course was uneventful, the patient being discharged from the hospital on the fifth postoperative day. Weight on discharge was 43 pounds. Four months later he had gained seven pounds, was eating well, and had been asymptomatic.

Comment

Peutz[1] originally described this condition as familial, and Dormandy[4] suggested that inheritance took place through a mendelian dominant gene. However, familial distribution has been present in only about 50% of the cases reported. Examination of the patient's parents and several members of his family failed to reveal any evidence of pigmentation such as seen in this boy.

Since the incidence of malignancy is high in multiple polyposis of the colon, it is important to realize that the polyp in the Peutz-Jeghers syndrome is apparently of different nature, the incidence of malignant degeneration being extremely low. Though some have described the lesion as an adenomatous polyp, others have maintained that the mass is a hamartoma. It does seem generally agreed that the lesion in the Peutz-Jeghers syndrome is not a pre-cancerous one, and though, from time to time, isolated examples of malignancy will be reported, some of these can be attributed to coincidence.[5]

Since the lesion is a local one and the symptoms produced are due to local obstruction, the treatment is the surgical removal of the individual lesions. Since the prognosis associated with this disease is excellent, conservative rather than radical surgical treatment is the treatment of choice. The polyps are usually multiple and may be found anywhere between the cardiac sphincter and the anus.[3] Though most of the polyps are of moderate size, examples have been seen where the polyps were very small. It is possible also to see incomplete examples of this syndrome, i.e. the characteristic pigmentation with no evidence of polyposis and the presence of polyps without pigmentation.

Further information about the Peutz-Jeghers syndrome may be found in the articles listed in the references particularly the ones by Dormandy.[4]

Summary

A case of Peutz-Jeghers syndrome in a seven year old white male is reported. The patient

experienced progressively increasing episodes of abdominal pain due to intermittent intussusception. An exploratory operation confirmed the pre-operative diagnosis with intussusception present. Two polyps were removed from the jejunum. The patient has remained asymptomatic postoperatively and is gaining weight. It is the authors' desire to stimulate interest in this clinical entity and encourage other physicians to report similar cases they may encounter.

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PARATHYROID ADENOMA WITH OSTEITIS FIBROSA CYSTICA

A CASE REPORT

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In 1888, a certain Herr Bleich fell from a ladder and sustained a fracture of the neck of the femur; soon afterwards he fractured his clavicle and then the shaft of one femur. He died. At autopsy, Von Recklinghausen recorded fibrosis of bone, cyst formation and Brown giant cell tumors, and added that "above the left thyroid gland, a lymph gland, red-brown in color is present."[1] This was the first record of a parathyroid adenoma with fibrocystic disease and pathological fracture. Then called sarcomas, these tumors are more correctly designated as giant cell tumors or osteoclastomas. More lately the term "Brown Tumor" for this specific lesion of hyperparathyroidism has been used by many pathologists. In light of these observations, after 1910 the number of times in which a parathyroid adenoma was discovered at autopsy of patients with lesions of the skeleton gradually increased. As early as 1915, Schlagenhaufer suggested that an attempt be made to extirpate the parathyroid adenoma in such patients.[2] Following his suggestion, Mandl in 1925 explored the thyroid region of a patient with Recklinghausen's bone disease and removed a parathyroid adenoma.[3] Remarkable improvement of skeletal disease in this patient was noted. Mandl also observed on repeated urinalyses, that excessive pre-operative urine calcium excretion was reduced to normal levels following the removal of the adenoma.

Between 1926 and 1945 reports of 295 operated cases had been published. During this same time, 42 parathyroid adenomas had been discovered at autopsy.[4] Today between 15 and 20 cases of parathyroid adenoma are diagnosed each year at the Mayo Clinic.[5] There are something more than 600 cases now reported in the literature.

The results of clinical studies in this field which were sparked by Mandl's original pub-

lication have elucidated many problems of the pathology of skeletal disease. Further, our knowledge of calcium and phosphorus metabolism have increased greatly, and light has been shed upon the pathogenesis and treatment of certain forms of nephrolithiasis. Etiology of many cases of renal failure have been explained.

The Various Syndromes Hyperparathyroidism

There are seven main syndromes which are present as the result of parathyroid adenoma.

1. Recklinghausen's Bone Disease.
2. Nephrolithiasis.
3. Nephrocalcinosis.
4. Hyperparathyroid crisis or acute hyperparathyroidism.
5. Digestive symptoms and signs.
6. A syndrome resembling diabetes insipidus.
7. Mental depression.

It would be interesting to note that in the case to be presented, only four of these syndromes appeared to be present, and three of them to a minor extent. The 4 manifestations in this case, were those of:

1. Recklinghausen's bone disease, which was predominant.
2. Digestive signs and symptoms.
3. A syndrome resembling diabetes insipidus.
4. Mental depression.

The last three were not clinically too important in this case.

Physiology and Biochemical Features of Hyperparathyroidism

It is gradually becoming evident that the parathyroid hormone has a dual influence upon the condition of the skeleton. This hormone stimulates the function of the osteoclasts, and in addition, increases the excretion of phosphate by direct action upon the kidney tubule. The hyperplasia and hyperfunction of osteoclasts caused by the hormone lead to rapid osteoclastic erosion of bone, resulting in fibrous osteitis. It is now generally believed that the increased osteoclastic activity which takes place under influence of parathyroid hormone primarily attacks bone matrix, resulting in liberation of calcium phosphate. As a matter of fact, before actual resorption of bone takes place under influence of parathyroid extract, changes of the bone matrix can be observed in the form of depolymerization of the polysaccharides. Further, injections of parathyroid extract cause a rapid increase in the mucopolysaccharides circulating in the blood. These findings indicate that under the influence of parathyroid extract destruction of mucopolysaccharides of the bone matrix, especially chondroitin sulfuric acid, takes place.

Albright and his associates in 1934 first demonstrated that parathyroid extract has a remarkable influence upon phosphorus metabolism that is completely independent of the osteoclastic absorption of bone. They observed that the injection of parathyroid extract in humans causes a considerable increase in the amount of phosphates excreted in the urine.[6] Harrison and Harrison demonstrated that the hyperphosphaturia caused by parathyroid hormone is due to a specific action which decreases the reabsorption of phosphates by the renal tubules.[7] Since this time, osteitis fibrosa cystica has not been used exclusively as a lead to diagnosis and the incidence of diagnosis has greatly increased.

Soon after the hyperphosphaturia induced by parathyroid hormone has started, the amount of calcium eliminated with the urine also increases. This hypercalciuria is probably due to the increased glomerular filtration caused by parathyroid extract, rather than to inhibition of the reabsorption of calcium by the renal tubules.

It is now generally accepted that the changes of calcium and phosphorus metabolism in the intact animal following injection of excessive amount of parathyroid extract are due to the combined result of the action of this hormone on the skeleton and on the phosphorus excretion by the kidney.[8] Enhanced osteoclastic bone resorption that takes place under influence of parathyroid extract must cause the liberation of calcium and phosphate. Under these circumstances, one might expect an increase of both calcium and phosphorus in serum and urine. However, as soon as the

parathyroid extract leads to erosion of bone and to liberation of calcium phosphate, the excess of liberated phosphate is excreted in the urine. This is due to the previously mentioned second action of parathormone in which phosphorus reabsorption by the kidney tubule is decreased.

Therefore, in patients with hyperfunction of the parathyroids — so-called hyperparathyroidism — the following biochemical syndrome nearly always is present:

(1) Hypercalcemia
(2) Hypercalciuria
(3) Hypophosphatemia
(4) Hyperphosphaturia

Without the presence of this biochemical syndrome, the diagnosis of hyperparathyroidism is doubtful, although normophosphatemia or hyperphosphatemia, particularly with renal impairment or azotemia is not too uncommon. Hypercalciuria may also occasionally be absent, especially if dilution due to polyuria is present. Repeatedly elevated serum calcium, however small, is the *sine qua non* for chemical diagnosis.

The osteoclastic bone resorption which takes place leads to secondary bone repair. When this repair develops, the activity of the osteoblasts causes an increase in the alkaline phosphatase of the serum. It follows that in hyperparathyroidism, an increase in alkaline phosphatase of the serum can almost always be expected when clear-cut bone changes are present in the roentgenograms. There are so few exceptions to this rule that with widespread bone resorption, the absence of an increased alkaline phosphatase content of the serum is a strong point against the diagnosis of hyperparathyroidism. In very rare instances, it is caused by carcinoma of one of the parathyroids. The frequency is as follows; Since 1925, some 600 cases of hyperparathyroidism caused by adenoma formation have been published, as contrasted with about 40 cases due to primary hyperplasia and about 15 or 20 cases due to parathyroid carcinoma.

In the Mayo Clinic cases, 59% of the adenomas removed weighed less than 1 gram. In the case to be presented the adenoma which was removed weighed nearly 5 grams. It might also be stated that in a check of the four Columbia Hospitals, including Veterans Hospital, no other case of pathologically proven parathyroid adenoma has ever been diagnosed in this area. In a personal communication, the author was told that three have been reported at the Medical College of South Carolina in Charleston.

Case Report

A 55 year old, white, married female was admitted to the South Carolina Baptist Hospital in Columbia on January 11, 1960 with a diagnosis of fracture of the neck of the left femur.

Past History

This patient began complaining of pain in the back and extremities somewhat prior to 1952, and her course was progressively downhill. She was first seen by a local physician in 1956, complaining of marked pain, weakness, etc. Family informants stated that they had over a period of years noticed a progressive bowing of the legs, and a shortening of the patient's stature. They stated that before her recent fracture, she had about 8 inches of diastasis between her knees. In 1956 a tentative diagnosis of "arthritis" and "neuritis" was made, and a series of injections were given the patient without beneficial effect. She was seen several months later with a growth in the distal end of the third left metacarpal bone. This tumor was resected on August 6, 1956. (Fig. 1)

The diagnosis made at this time by the pathologist was that of giant cell tumor of the epulis type. (Fig. 2)



Figure 1

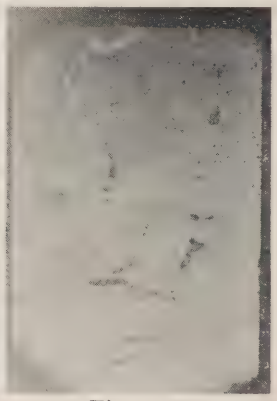


Figure 2

Figure 1—Lesion in 3rd metacarpal found in July 1956. After removal was called "giant cell tumor of the epulis type" by the pathologist. Note the subcortical erosion present.

Figure 2—Histology from lesion in Figure 1. Bone has been replaced by a highly cellular fibrous tissue containing hemosidirin and many multinucleated giant cells.

This patient was seen sometime later by a local phycian, complaining of tiredness, weakness, etc., and was advised to have two weeks of bed rest. She was then persuaded by her neighbors to go to a chiropractor for treatment, which she did for some time, and obviously without beneficial results. She was therefore not followed for a long while, but roentgenograms were taken on January 1, 1957, which were fortunately available for our study in this case. She apparently was not seen regularly after this time until she was admitted to the Baptist Hospital with her present illness.

Upon reviewing her x-ray films, there was an obvious low fracture of the neck of the left femur, and infratrochanteric areas of ground glass appearance with a lobulated type of structure, obviously a type of fibrous tissue replacement of the bony elements. However, on this same film, evidence of massive deossification of bone was seen in the pelvis and spine and the condition was accepted at this time as that of massive osteoporosis. (Fig. 3) It was felt at this time that the emergency must be met, and the question was whether or not this demineralized bone would

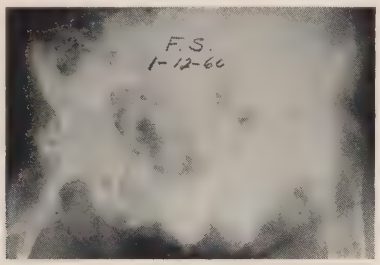


Figure 3

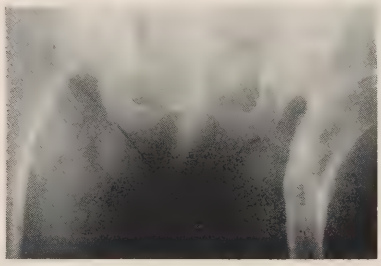


Figure 4

Figure 3—A.P. of pelvis taken on admission of patient Jan. 11, 1960. Fracture of femoral neck is present. General deossification of the skeleton with loss of transverse striations is to be noted. Brown tumors with a lobulated structure and ground glass appearance can be seen in the upper femoral shaft.

Figure 4.—Roentgenogram taken 10 months after adenoma removal. Note complete healing of femoral neck in perfect position and complete healing of subtrochanteric fracture. Reossification of bone is occuring.

On the evening before admission to the hospital, that is January 10, 1960, this patient states that she was in the bathroom and made some sort of awkward movement and felt something "slip" in her hip. Prior to this time she had been barely able to get about with the aid of crutches because of widespread skeletal pain. After this accident, she complained bitterly of pain in the left hip and was brought to the hospital on January 11th. In her past history, she stated that she was never anorexic, but did sustain a weight loss of approximately 40 pounds over a period of a year. She had had no vomiting, but was markedly constipated. There were no dietary indiscretions. The diet was apparently normal, and well-balanced. She complained that for several weeks prior to her admission that she had had some polyuria and nocturia, to such an extent that at times she had almost complete urinary incontinence.

Examination

The patient was a well-developed, rather malnourished, apathetic female who lay quietly in bed and was non-complaining. She held her left thigh and foot in the typical externally rotated position that would be expected with a fracture of the femoral neck and with obvious shortening of perhaps 2 inches of the affected extremity. Any attempt at manipulation of the hip was painful.

hold metal for internal fixation. A decision was made to attempt a femoral head replacement operation and this patient was taken for surgery on January 14, 1960.

This patient was placed in the lateral-prone position and a posterior approach to the hip was made, extending from the lateral side of the femur, curving inward and low on the buttocks. Dissection was carried down to the hip joint and it was noticed at this time that there was a marked looseness below the trochanter, even though manipulation and internal rotation had been quite gentle. Dissection was then carried down the lateral side of the femur, and, as expected, a markedly comminuted infratrochanteric fracture was found. The bone was of eggshell thickness and the interior of the bone consisted of a solid, rubbery, gritty type of material. A reflection was then made at surgery, as to the roentgenographic appearance of the patient's bone, and some of these spicules of bone were submitted to the pathologist for examination. (Fig. 5) The wound was closed and the patient placed in a balanced traction until further attempts at definitive diagnosis could be made. Incidentally, when the Steinmann pin was inserted through the tibia, preparatory to placing the patient in balanced traction, the pin slipped through the bone with the ease of placing a pin through a mass of cheese.

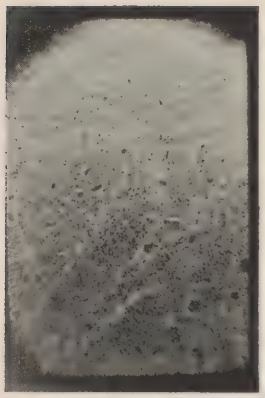


Figure 5



Figure 6

Figure 5—Tissue submitted to pathologist on attempt at prosthetic replacement of femoral head. Compare to tissue, Fig. 2. Note the abundance of giant cells in addition to increased fibrous cellularity.

Figure 6—Brown tumor, 3rd Proximal Phalanx. Loculated in appearance, has a "ground glass" consistency and a lacy subcortical appearance. This roentgenogram taken in Jan. 1960, 4 years after removal of the previous tumor of the metacarpal.

A partial skeletal survey was then made and the histopathological sections were studied. (Fig. 6)

After reviewing the preceding data, it was felt that parathyroid disease must be considered. With this in mind, blood chemical studies, as well as urinary studies were then undertaken and their results are tabulated as follows:

With the preceding data at hand, that is, of this

Date	Normal 10.4 Calcium	Normal 3.0 - 5.0 Phosporous	Normal 1.5 - 5.0 Alkaline Phosphatase	
Jan. 15	13.0	2.55	6.25	
Jan. 24	11.5			
Jan. 25	12.0			
Jan. 27	13.0	2.7	7.1	
Feb. 9	11.0	1.75	5.0	
Feb. 22	6.0	4.4	12.4	(post-operative)
Mar. 1	6.0	5.65	7.95	(post-operative)
Mar. 11	8.0	5.1	4.95	(post-operative)
May 26	9.5	5.25	1.35	(post-operative)

Feb. 1 Urinary Calcium (on 24 hr. spec. Baur - Aub diet) 330 mg. (Normal 100 mg.)

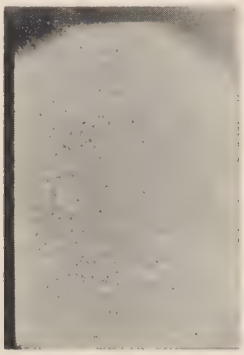


Figure 7

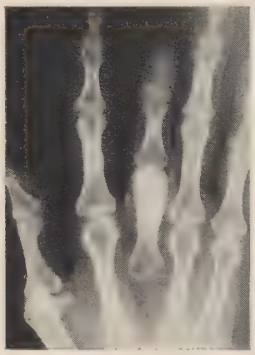


Figure 8



Figure 9

Figure 7—Section from parathyroid adenoma. Chromophilic clear cells without intercellular matrix.

Figure 8—X-ray taken 4 months after parathyroid adenoma removal. A great deal of reossification in the lesion has occurred. Compare with Fig. 6.

Figure 9—Four months after adenoma removal. Note thinned cortex, distal radius and ulna. Note healing in Brown Tumor of metacarpel as noted in Fig. 8. Note also the periosteal proliferation on the radial side of the ulna.

patient's history, roentgenographic appearance of her bones with progressive demineralization and fibrous tissue replacement of bone, along with the appearance of the histological sections and with the blood chemical findings, it was felt that there was enough evidence at hand to make a definite diganosis of parathyroid adenoma. Though no adenoma could be felt in the area of the thyroid gland, this patient was taken for surgery on February 8, 1960 and an exploration was made for a parathyroid adenoma. Under the right inferior pole of the thyroid gland there was noted to be a tumor, which was extra-capsular as far as the thyroid gland was concerned, had its own distinct and separate capsule. This tumor, measuring approximately 3 cm. in diameter, was removed. Exploration was made for other tumors and none was found. Frozen section revealed the presence of parathyroid clear cells and the diagnosis was considered complete. (Fig. 7)

Post-operative course: This patient had a rather uneventful post-operative course and her post-surgical management was by her attending physician, who kept her during the remainder of her hospital stay on large doses of calcium by mouth, and large doses of vitamin D. Her post-operative chemical studies are shown in the above chart.

Although it is not the policy of the author to treat with traction in the home, because these people were of moderate economic circumstances and there was so much doubt as to the length of time that would be required for bone healing (Figs. 8, 9) this patient's family arranged to have an overhead traction apparatus made at home. The patient was placed in balanced traction in her home for a period of two and one-half months. She was seen weekly and taken to the hospital on two occasions for x-ray examination and blood chemical studies. The last x-ray film taken 10 months subsequent to the parathyroid surgery is shown in Fig. 4. The patient has now gained some 40 pounds in weight, has been entirely free of pain, has a good appetite, and has a good mental status. She has been walking without any weight-bearing aids since December 1960, which was 10 months after her hip fracture and 9 months after the adenoma removal. She was last seen in November 1961 and continued to do well.

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TEXTBOOK OF OPHTHALMOLOGY — 7th Edition. Francis Heed Adler, M. D. W. B. Saunders Co. Phila. 1962. $9.00.

Dr. Adler has again produced a most comprehensive and practical new edition of the late Dr. Sanford Gifford's original textbook of Ophthalmology. In his preface to this latest edition the author states: "so many changes have been made in the last four editions from Gifford's original text that little remains even of the skeleton."

Probably the most outstanding of the innovations of the 7th Edition is found in the first chapter, entitled: "Symptomatology of Eye Diseases—Ocular Symptoms, Visual: Ocular Symptoms, Nonvisual." Herein there is a most skillful arrangement of various eye complaints together with references in the text by page number wherein the particular symptom is correlated with the clinical entity responsible for its occurrence.

Whereas the main purpose of this text, as stated by the author, is to furnish a textbook of ophthalmology for the medical student and general practitioner, the field of its content is most thorough and reflects this author's scholarly attainments, his vast clinical experience as well as the picture of the pure scientist. There are in this connection, one might say, "echoes" in this text of the author's "Physiology of the Eye," published some years ago. His prose is of that lucidity which identifies the writer as a great teacher, and this reviewer can verify this fact since he was years ago his pupil as a resident at Wills Eye Hospital in Philadelphia. Though somewhat prejudiced, this reviewer recommends this Textbook of Ophthalmology to all medical students, general practitioners and ophthalmologists.

Pierre Jenkins, M. D.

Medical College Clinics

POISONING OF THE MONTH

MARGARET Q. JENKINS, M. D.

Department of Pediatrics

A 4 year old, white male (R. A. M.) and his 6 year old cousin were brought to the Emergency Room on Dec. 3, 1961 with marked ataxia. The grandmother who cares for these children had been preparing dinner for the family when the two children came in staggering. When questioned, the children said they had sniffed gasoline from a 5 gallon can with a nozzle which was in the pump house. When seen in the Emergency Room about an hour later, the children had gastric lavage performed but no odor of gasoline was present in the aspirated material. The history was obtained from the mother that the previous night in the children's presence, a pregnant aunt had been talking about "taking gas" for the delivery of her baby, and the aunt made the statement that it was "just like the gas in the tank." The children were discharged following their treatment and when the Public Health Nurse made the home visit to their family later she found that the children had actually been sniffing the gasoline lately once or twice a week. She instructed the family to watch them more closely in the future. The yard was found to be cluttered up with all kinds of motors, broken trucks, cars, lawn mowers, gas lines, rubber hose, paint cans, an old lavatory, electrical wiring, old tires, old batteries, an old washing machine, broken bottles and a pile of milk cartons and other debris. The uncle of the two children involved in the episode apparently kept the yard cluttered, working with all kinds of motors, trucks and tractors. On a later visit the Nurse commented that the pump house had been torn down and the yard cleaned up.

On March 11, 1962, R. A. M. was again brought to the Emergency Room, this time in coma, but responding to painful stimuli, with the history that someone had borrowed some gasoline and left the can by a tree. When the mother looked for the child she finally found him under the house with a hose in his mouth leading to the gas can which was almost empty. The patient was in a coma at this time. The patient was subsequently admitted to the hospital and after having oxygen administered responded satisfactorily.

Apparently the two children have become habitual gasoline sniffers because of the suggestion given them in overhearing the conversation of adults, and after trying this and apparently enjoying the effects of the sniffing have continued to do so at every opportunity. Certainly the home environment and emotional aspect of this family is far from stable and it is hoped that psychiatric help will be able to alleviate part of this problem.

Successful repair of a bullet wound of the abdominal aorta. Bradham, G. B., Nunn, D. B., Brailsford, L. E. (Charleston) Ann Surg 155: 86-89, Jan. 1962.

A case of successful repair of a bullet wound of the aorta is added to the 23 cases in the literature. In that only 15% of such injuries survive one hour, immediate clinical diagnosis, swift control of the point of bleeding, and rapid blood replacement are deemed mandatory. At laparotomy, manual compression of the proximal aorta prior to retroperitoneal dissection aids in minimizing blood loss until aortic clamps are placed proximal and distal to the wound. Debridement of arterial wound edges and continuous arterial suture technique suffice for the usual repair. Attention to possible additional wounds is emphasized when the arterial repair is secure.

Effect of d-triiodothyronine on hypercholesterolemic subjects, by N. B. Baroody and W. G. Baroody. (Am. J. M. Sc. 243:338-240, March 1962)

Fourteen patients with hypercholesterolemia of various etiologies were given D-Triiodothyronine (0.5 to 1.0 mg. daily) and studies for 9-12 months. Eight patients had symptomatic ASHD, 3 had idiopathic hypercholesterolemia, 1 had HCVD, 1 had biliary cirrhosis, 1 had nephrosis. Cholesterol levels, pulse rate, body weight and associated side effects were carefully checked every 2-4 weeks. Observations and tests for hyperthyroidism were also conducted before and after the study. Ten of 14 patients showed a significant decrease in serum cholesterol (average drop 32.5%). Weight loss occurred in 6 patients (average decrease of 9.5% from pre-treatment weight). Four patients showed increased irritability and nervousness and of these 3 had increased angina. No electrocardiographic changes were noted. Three patients showed some evidence of hypermetabolism. Two patients with familial hypercholesterolemia showed no significant change in cholesterol levels after treatment. No serious side effects or reactions to D-Triiodothyronine were observed.

President's Page



I recently visited our South Carolina Medical College on the occasion of the opening of its one hundred and thirty-fourth session. Present at this event were students of medicine, pharmacy and nursing and some of the faculty members. They now have on the faculty one hundred and fourteen full time instructors who compose a well organized and highly efficient teaching staff.

It was my pleasure to participate in the opening exercises along with Dr. H. R. Pratt-Thomas, President of the Medical College, Dr. Vince Moseley, Dean of Clinical Medicine, Dr. C. M. Smythe, Dean of the School of Medicine, Dr. William Prout, Dean of the School of Pharmacy, Miss Ruth Chamberlain, Dean of the School of Nursing, Dr. John Brewer, Chairman of Council, South Carolina Medical Association, Dr. John May, President of the Alumni Association, Dr. Charles Hanna, President-elect of the Alumni Association, Dr. Samuel Miller, Vice-president of the South Carolina Medical Association and Dr. Robert Wilson, President-elect of the South Carolina Medical Association. Following this session, I was privileged to listen for several hours to a most enlightening discussion of the many medical problems common to all areas of our state—things that ranged from post graduate medicine to nursing education and the care of the patient. Suggestions were made which were indeed thought provoking.

Dr. Pratt-Thomas took a group of us on a tour of the physical plant. What I saw pleased me. It is good to know that progress is being made toward adequate facilities for full participation in teaching in all fields of medicine and toward the necessary research for seeking knowledge and know-how. This program will later open many doors in the problems of health for the people of South Carolina and of our nation.

Among the new improvements are the enlargement of the Psychiatric area on the tenth floor of the Medical College which includes a new Pediatric wing with glass walls so that the small patients can be observed by the third person. An intensive Nursing Ward is being completed. The spacious Research building will lend much needed room to the projects now being carried on in cramped quarters and for additional projects to be instigated. It is amazing what they are doing at our Medical College.

We need a new Library building and a building to house the School of Dentistry which is only a school on paper at the present time.

James H. Gressette, M. D.

Editorials

The A. M. A. Institute

Initiated several years ago as the "Public Relations Institute," this meeting has assumed a broader character and offers an opportunity for soul-searching and projection of ideas for the members of the A.M.A. The latest Institute held in Chicago August 30-31 covered a variety of subjects, all of which deserved attention, but most of which were discussed only in an analytical rather than an executive way.

Your editor had the privilege of attending this meeting and sitting on hard seats for its two-day duration. The featured speaker was Dr. C. K. Higgins, a Canadian, who had a dissertation dealing with the rights of man and application of these rights to medical matters. Excerpts from his address appear elsewhere in this *Journal*. The panel on medicine and religion brought out the fact that very often there was not sufficient contact between the physician and the clergyman and that such defects might be corrected. The participants spoke of seminars in large centers, of conferences locally between physicians and the clergy, and of the year-long hospital internship available for the clergyman. It was considered that there was no implicit dividing line between the two professions in their association with the patient, and there seemed to be a feeling that the physician had, perhaps of necessity, assumed more of the duties of the clergyman than was desirable to either party, or as it was put, in some cases the physician had defrocked the clergy and had ordained himself, as the result of the request of the patient for advice on all sorts of questions. A middle ground was desirable. There were discussions of the congressional investigation of the modern county medical society, of medicine and press, and of medicine's role in the approaching political activities with their threatening connotation.

Community health and the part of the individual physician and the medical society in developing the desirable health programs was another subject, as was a discussion of medical ethics and licensure with comment on the activities of chiropractors, optometrists, and osteopaths.

A new film was shown in which Dr. Annis expounded the present status of medicine from the political standpoint and Dr. Annis himself addressed the meeting on "Influencing Representative Government" at the closing luncheon.

All in all, this was a worthwhile meeting which served to present ideas and elicit discussion. While no positive action was carried out or expected, the seeds for future growth and activity were well planted.

A Neglected Custom

In the not too distant past, most people meticulously observed the custom or courtesy of writing a personal note to acknowledge a favor, an invitation, or a congratulatory note on some honor or achievement.

I am moved to this writing by my receiving recently a number of letters from my fellow physicians urging me to vote for some political candidate friend.

All except one of these numerous printed outpourings were adorned with an impersonal facsimile of a signature and were mailed from a political headquarters. However, one of these letters was personally signed by the doctor himself. You may readily imagine which of all these letters made a really significant impact on my decision for voting.

I have noticed an increasingly common custom lately whereby the physician acknowledges a referral of a patient by means of a printed card on which his secretary writes the name of the patient (there must be some individual identification). Often there is no acknowledgement whatsoever by the doctor or his office. Contrast this, in your own mind, when you have referred a patient, and you receive a personal letter, personally signed, with a detailed and considerate report of what the doctor has done for your patient.

My wife and several friends were recently discussing a point of etiquette concerning the custom of many funeral directors of providing a printed form to mail to friends of the family to acknowledge gifts of flowers or notes of sympathy. They felt that, although the immediate family might be overwhelmed with grief at the time, that a little written note of thanks penned at some later time should properly acknowledge the friendly attention.

Some folks, over the years, have made a habit of sending a little note or card congratulating some person or friend who has recently been honored or has accomplished some thing noteworthy. I have often received from such a person to whom I sent one of my little yellow note cards a genuinely grateful response although none was expected. One of the nicest follows:

"It was good of you to send a card of congratulations and I appreciate it very much. While the honor referred to is not so great, having people like yourself take the trouble to write me about it is of tremendous importance and I thank you for it."

In these days of automatic printing machines, when every doctor's office (or nearly every one?) has a copying machine of some kind which turns out facsimiles by the score at the touch of a button, the handwritten note or even the handwritten signature takes on added graciousness and meaning.

JOHN VAN DE ERVE, M. D.

Which Paper D'Ye Read

Conflicting opinions on the subject of the situation of the profession in Great Britain are frequently found in the journals of today. We note in one of them, the old reliable *British Medical Journal*, two rather divergent statements as to the matter of departures of medical professional people from the British Isles. In one issue the Minister of Health says that the story of the departure of numerous physicians is nonsense and that the decrease in consultants is not real. He cites the increase in the number of consulting anesthesiologists, but he does not note that these gentry have increased tremendously in various other areas. Certainly in our small local compass they have been multiplying with astonishing rapidity.

The Minister does concede that forty percent of the hospital house staff appointments are of physicians from overseas.

The other article in the same journal states that 600 to 700 physicians are leaving Britain every year and that they find the health service unattractive "economically, professionally, and idealistically." It states that there are fewer medical students and that the United States and Canada acquire more than 300 doctors a year from England.

We wonder whether somebody in England might be doing some of the same kind of distortion of medical figures to which we have become accustomed, but resent, under the Kennedy-Ribicoff-King-Anderson, etc. effort to reduce American medicine to the same status as that of the British profession.

Journal Distribution

For several years past *The Journal* has been sent without cost to the members of the house staffs of the various hospitals of the state and to all of the members of the senior class at the Medical College. It was thought that this gesture might do something toward increasing information about the activities of the Association and organized medicine in general and that the courtesy subscriptions would be of some value to the recipients. Because of the frequent changes of address during the summer, the Journals have been sent only from October through June inclusive and it is proposed to resume this service with the October issue.

Drugs

One of the larger pharmaceutical firms (Smith, Kline & French) points out that while our government is apparently working toward removing trademarks from prescription drugs, Russia is now encouraging the use of specific trade names. Whether this is a good example for us is a question. This *Journal* is still of the opinion that the logical arrangement to cover drug identification and manufacturer's reputation is a combination of the generic name and the name of the manufacturer.

HILL'S BILLS

Senator Hill, promoter and defender of generous appropriations for HEW, met unusual opposition in the Senate this year, says *Medical World News*. With other opponents, radical Javits proposed to withhold Hill-Burton funds from hospitals having provision for racial segregation, attacking the clause in the Act which allows "separate but equal" facilities. This clause is a provision which the Administration is seeking to abolish.

BUSINESS

The business problems of the doctor no longer will have to depend entirely on *Medical Economics* or other publications for solution. The first national convention on medical practice management is scheduled for an early date and will concentrate on the non-clinical aspects of the doctors' practice. It will have exhibits, hospitality rooms, speeches, and the usual paraphernalia of a medical convention. Business and management consultants will appear. A cocktail party is set up on a Madison Avenue scale—"all you can eat and drink." The place is Las Vegas, which to an uninformed writer seems about as unbusiness-like a location as could be selected. However, there should be a great deal of information to be had out of this sort of meeting.

SERVICE NO

Now, says the director of the Johns Hopkins' Hospital, medical schools rather than hospitals should have the major responsibility in intern and resident training.

Sounds like a big load for medical schools to carry and much study will be necessary before any plans can be made to implement this suggestion. Whether the suggestion is sound or not might be debated. What the administrator proposes is to extend the university influence to more hospitals and more clinical settings in order to improve educational experience. As in many similar pronouncements, the idea of the house staff furnishing service is put far into the background. The emphasis is on learning, and unfortunately sometimes such emphasis goes even to the point of almost obliterating the necessary service which every house staff should offer.

KERR-MILLS

The doctors of Hampton County have published at their own expense in their local newspaper a full exposition of the benefits obtainable under the Kerr-Mills bill and under the Public Assistance Act. This is a very valuable step, and it is to be hoped that other societies will feel stimulated to follow this excellent example.

JOURNAL ADS

As the editor receives little audible or visible praise for *The Journal*, he feels that he might take the opportunity to pat the publication on the back in a mild way. The agency by which the greatest part of our advertising is handled informs us that the whole group of state journals is 9.3 per cent below its average amount of advertising. The figure refers to money. The number of advertising pages is down 5.5 per cent on the average, and our South Carolina figure is 6 per cent. However, the amount of our receipts is down only 1.09 per cent, far less than the average and very considerably less than some individual journals. For peace of mind we assume that the reason for our small loss is that the advertisers consider *The Journal* a suitable medium for expression of their messages, and we hope that this means that they find the Journal acceptable as a whole. Do you?

WELFARE BOARD

We note that Dr. W. L. Young has been named to a seat on the Hampton County Welfare Board. It is a happy circumstance when medicine is represented on a board of this kind, which is sometimes overly influenced by non-medical people. This has no specific reference to Hampton, but to welfare boards in general.

HOPE

A hopeful note for the supply of physicians —Clemson's pre-medical enrollment, which has been declining for some years, now shows a slight increase.

News

Parasites Found At High Incidence In Carolina Area

An unusually high incidence of two types of intestinal parasitic infestations persists in an area of South Carolina despite extraordinary control efforts by local health authorities, the joint meeting of the American Society of Parasitologists and Helminthological Society of Washington was told.

A study of 212 persons in Beaufort County showed that 64 per cent were infected with roundworms (Ascaris lumbricoides) and 37 per cent were infected with whipworms (Trichiuris trichiura), according to the report by Drs. Geoffrey M. Jeffery and Kenneth O. Phifer, of the National Institute of Allergy and Infectious Diseases laboratory in Columbia, S. C., and Dr. Donald E. Gatch, a practitioner of Buffton, S. C.

The prevalence of the infestations, much higher than previously found in the state, indicates an "island" of high incidence for the area, they reported. Some evidence of clinical disease due to the parasites was also reported by the investigators. In addition to typical gastroenteric complaints, there was bronchial and pulmonary infestation, and eosinophilic levels in children infected by roundworms were significantly higher than normal.

Single doses of piperazine cured about 60 per cent of the 135 persons treated for Ascaris infestations, but was ineffective against Trichiuris and hookworm, which affected about 4 per cent of the patients.

Repeated mass single-dose treatment campaigns offered the possibility of control in the absence of radical change in sanitation and personal habits necessary for control, the investigators suggested.

Medical Tribune

Dr. Hanna Speaks on Spartanburg Medical Facilities

Dr. Charles B. Hanna addressed the Sertomans recently on the need to increase the medical facilities of Spartanburg County. He noted that only five new doctors have been added in the county within the past 10 years. Dr. Hanna also spoke on the "small dose of socialism" which is the King-Anderson Bill.

Lancaster's Emergency Health Plan Approved

The textile center of Lancaster is the first county in the state to receive approval from the S. C. Civil Defense Agency for an emergency health plan in line with current national civil defense concepts. Designed to provide emergency health and medical services in the event of natural or war caused disasters, the plan was created by the Lancaster County - City Civil Defense Agency, from a health guide created by the State CD Agency. Dr. L. A. Nimmons, County Health Officer, is head of the emergency health plan.

Committee On Mental Health Legislation, South Carolina Medical Association

Dr. James B. Galloway, Chm.
1513 Hampton Street
Columbia, South Carolina
Dr. Hyman Marcus
511 Carolina Avenue
Orangeburg, South Carolina
Dr. James J. Cleckley
55 Doughty Street
Charleston, South Carolina
Dr. Allan P. Bruner
11 West Calhoun Street
Sumter, South Carolina
Dr. Robert G. Thompson
1209 North Fant Street
Anderson, South Carolina
Dr. Joe E. Freed
South Carolina State Hospital (Drawer 189)
Columbia, South Carolina
Dr. Joseph J. Nannarello
610 Pendleton Street
Greenville, South Carolina

South Carolina Medical Unit On Active Duty

The 446th General Hospital, Army Reserve Unit, from Columbia, Greenville, and Charleston had two weeks annual active duty for training at the Womack Army Hospital, Fort Bragg.

Col. James G. Shaw, a Columbia physician and commanding officer of the 446th, said that while at Fort Bragg, each member of the 446th received on the job training. Medical and surgical personnel were engaged in the care and treatment of patients in the hospital.

446th personnel includes doctors, nurses, dentists, therapists and medical technicians and corpsmen. The unit had its own administrative headquarters, food service, supply section, and maintenance and utilities sections.

Douglas C. Appleby, M. D. announces the opening of his office for the practice of general surgery at 126½ Rutledge Avenue, Charleston.

Whetsell Named To Medical Examiners Board

Governor E. F. Hollings has appointed Dr. William O. Whetsell of Orangeburg to the State Board of Medical Examiners to succeed Dr. W. R. Tuten, deceased.

Reappointed to Board membership was Dr. George R. Wilkinson of Greenville.

Both men were appointed for terms to expire April 23, 1966.

Coming Meetings

The American Academy of Pediatrics will present a postgraduate course on "Current Topics in Genetic and Metabolic Diseases" at Duke University on April 4-6, 1963. Dr. J. Harris will be in charge of the course.

The Southern Chapter of the American College of Chest Physicians will hold its annual meeting November 11 and 12, 1962, at the Hotel Fontainebleau, Miami Beach, in conjunction with the annual meeting of the Southern Medical Association (November 12-15). All physicians are invited. There is no registration fee.

Doctor Finds Practice Tough

Dr. Nick Forlidas, who joined Dr. Hugh Wells and Dr. Lane Mays at the Medical Clinic last month for the practice of medicine, has announced that he is leaving Seneca.

Dr. Forlidas said that he is applying for recall to active duty with the U. S. Army and hopes to study for specialization.

He released the following statement:

"After observing the role of the general practitioner of medicine in terms of his responsibilities to his community, his hours of work, and his total coverage of the practice of medicine in a community such as Seneca, in relationship to my own abilities, my goals of life, and my ideas of service, I realize my best area of service is the area of specialization. For the above reason I am applying for recall to active duty with the Army to do a medical residency and leaving the private practice of medicine."

S. C. Chapter of the American Academy of Pediatrics Elects Officers

At the Annual Meeting of the South Carolina Chapter of the American Academy of Pediatrics, held September 11, the following officers were elected: Dr. Henry W. Moore of Columbia, Chairman; Dr. B. O. Ravenel of Charleston, Vice-Chairman; Dr. C. Benton Burns of Sumter, Secretary-Treasurer, and Dr. Ethel M. Madden of Columbia, Fellow at Large, term expiring 1964.

For the South Carolina Pediatric Society, Dr. Clarence Lyles was elected Secretary-Treasurer.

Clay W. Evatt, M. D., Ophthalmology and Otolaryngology announces the association of Clay W. Evatt, Jr., M. D., Ophthalmology at 91 Rutledge Ave., Charleston.

Dr. Faison On National Cancer Board

Dr. Thomas G. Faison of Columbia has been appointed as national program consultant to the Medical Affairs Department of the American Cancer Society.

A retired Army medical officer with the rank of colonel, Dr. Faison was formerly post surgeon, Medical Corps, at Fort Jackson. From headquarters in Columbia, Dr. Faison will serve the society's divisions east of the Mississippi.

TB Clinic Opens At Laurens

A special tuberculosis clinic at this county's Health Department has begun operation.

Dr. Von A. Long, medical director for the Laurens County Health Department, is cooperating with the clinic, one which has a physician and public health nurse in attendance to serve patients referred by family physicians and public health nurses.

The clinic is a part of a special project sponsored by the South Carolina State Board of Health and the United States Public Health Service.

Mental Health Staff Increased

An ex-Army officer and a graduate of Vanderbilt University have joined the once-shrinking staff of Florence-Darlington Mental Health Center.

Dr. Alexander Donald was formerly head of the neuro-phychiatric service at Ft. Jackson. A psychiatrist, he is now director of the clinic.

Dr. Robert Mack recently graduated from Vanderbilt at Nashville, Tenn. and is a clinic psychologist.

Portrait Of Dr. Prescott In Hospital

A portrait of the late Dr. E. H. Prescott, native of Edgefield, will be hung in the conference room of the City-County Hospital at La Grange, Ga., where Dr. Prescott was public health officer.

Dr. Prescott was first an officer in the U. S. Navy and after retirement from that service went to La Grange.

PAPERS INVITED FOR NEXT SOUTH CAROLINA MEDICAL ASSOCIATION CONVENTION

The scientific program of the next annual convention of the S.C.M.A. (May 7, 8, 9, 1963 at Myrtle Beach) will include several 15 minute presentations by South Carolina physicians.

Abstracts of 200 words are invited by the Program Committee. These may be submitted by November 15th to Dr. Dale Groom, Chairman of the Committee, at the Medical College of South Carolina, Charleston.

Conference of the U. S. Civil Defense Council

The eleventh Annual Conference of the United States Civil Defense Council will be held at the James White Memorial Auditorium-Coliseum, Knoxville, Tenn., October 15-19.

GGH School Is Accredited

Accreditation has been given the Greenville General Hospital School of Medical Technology by the American Medical Association.

Dr. Bates Talks To Secretaries At Dinner Meet

Greenwood urologist, Dr. P. L. Bates, spoke recently to members of the Emerald Chapter of the National Secretaries (International) Association at their dinner meeting at Holiday Inn. Dr. Bates outlined the basic concepts of "Socialized Medicine," for the group.

Dr. Long Is Honored

A testimonial was tendered Dr. Lawrence Winfield Long July 29 in the auditorium of Bethany Baptist Church in Jonesville not far from the birth place of the physician-surgeon and superintendent of the Union Community Hospital. Dr. Long began the practice of medicine in Jonesville about thirty years ago.

Working as a shoeshine boy and barber he finished his secondary preparation at Walden Institute in Nashville and matriculated at Howard University where he did pre-medical work. He completed his education at Meharry Medical College.

He returned to Jonesville, but shortly afterwards moved his office to Union and began to pioneer the movement which resulted in the establishment of the Union Community Hospital.

In 1957 he was voted the national doctor of the year.

Dr. McLean Opens Office in Columbia

Dr. George Edward McLean has opened an office in Columbia for the practice of plastic and reconstructive surgery.

Dr. McLean graduated from Emory University, Phi Beta Kappa, and from Emory Medical School. After three years of service in the U. S. Navy Medical Corps, Dr. McLean took four years in general surgery at Emory and the Veterans Hospital in Atlanta and then two more years in plastic surgery with nationally recognized plastic surgeons in Salt Lake City, Utah.

Dr. Cone Honored

Dr. Wallis Cone was honored July 25 for having practiced medicine for 50 years in Williston and Barnwell county. In observance of the day, which was proclaimed "Dr. Wallis Cone Day," a reception was given for Dr. Cone at his home in Williston. Among those present were members of the Barnwell County Medical Society, Dr. James Gressette of Orangeburg, and Dr. Cone's two sons, both of whom are doctors.

VA Hospital Staff Adds 2 Doctors

The recent addition of two doctors to the staff of the Veterans Administration Hospital here has been announced by Dr. Chalmer Davee, director.

They are Dr. Reinhard A. W. Westphal and Dr. Francisco Lequerica.

Dr. Westphal, an orthopedic surgeon, is a native of Stettin, Germany and received his medical degree from Albert Ludwigs University in Germany in 1953.

A new staff physician, Dr. Lequerica is a 1920 graduate of the University of Havana in his native Cuba.

New Publication on Cancer Research

The National Cancer Institute of the Public Health Service, U. S. Department of Health, Education, and Welfare, announces the publication of "American Scientists in Cancer-Virus Research." This is a bibliodirectory of current studies.

The directory, listed as Public Health Service Publication No. 946, may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. The single copy price is 30 cents.

Association of Physicians and Surgeons

New national officers of the Association of American Physicians and Surgeons include Dr. Thomas Parker, Greenville, President-elect, and Dr. Thomas G. Goldsmith, Greenville, Treasurer. Delegates from South Carolina are Dr. Thomas G. Goldsmith, Greenville, and Dr. Vince Moseley, Charleston.

Educational Television for Nurses

The success of the program for physicians sponsored by the Medical College of South Carolina has led to the inauguration of a series of presentations intended for nurses. This series is sponsored by the Medical College and conducted by the South Carolina Hospital Association with the financial assistance of the Duke Endowment. This will be a program presented on two successive days each month and will cover such subjects as obstetrical nursing, care of the burned patient, care of the cardiac patient, and the like. It should be a valuable new departure.

Program for Next Annual Meeting Begins to Take Shape

The program committee, Dr. Dale Groom, Chairman, reports that arrangements have been made with the Medical College of Georgia to put on the greater part of the scientific program for the next annual meeting in May, 1963. There will also be two guest speakers from outside the state, and local speakers as usual.

It is anticipated that the program will be composed largely of panel discussions with audience participation. Protocols will be prepared to expedite the discussions.

Hospital Adds New Services

Two new services have been added at Byerly Hospital in recent months. They are a recovery room for intensive care of post-operative patients, and an emergency room staffed every day from 4:00 p. m. to 12:00 midnight.

Piedmont Postgraduate Assembly

The Piedmont Postgraduate Clinic Assembly met Sept. 19-20 at the Clemson House, where the Anderson County Medical Society sponsoring group acted as host to Piedmont area physicians from Georgia, North Carolina and South Carolina.

Main speaker was Dr. George M. Fister of Odgen, Utah, president of the American Medical Association.

Other prominent physicians featured on the program included Dr. George H. A. Clowes, newly appointed head of the Medical College of South Carolina's department of surgery; Dr. Eugene B. Stead, chairman of the department of medicine at Duke University; and Dr. Joseph Little of the department of pediatrics at the Vanderbilt University School of Medicine.

Southern Medical Association

The program of the Section of Ophthalmology and Otolaryngology of the Southern Medical Association which will be held at the Fontainbleau Hotel in Miami Beach, Florida, November 12-15, 1962, (the week following the Academy Meeting), will feature two live television clinics. One will be on Diseases of the Cornea, and the other on Surgery of the Cornea.

Grant Given for Program of Accreditation for Nursing Homes

The John A. Hartford Foundation has given a grant of $49,500 to the Hospital Research and Educational Trust to develop a program of accreditation for nursing homes and institutions other than hospitals which give in-patient care. The work will be carried out by the Joint Commission on Accreditation of Hospitals which is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association and the American Medical Association. The Joint Commission now accredits nearly 4,000 hospitals, which admit nearly 85% of all patients. As with the hospital program, the new long-term facility program will be voluntary, with the institutions making application for survey.

Young Doctors Open Offices

Dr. David Tribble has moved to Anderson to practice general surgery in association with Drs. Young, Perry and Bailes. A graduate of Vanderbilt University School of Medicine, Dr. Tribble served his internship at Grady Memorial Hospital, Atlanta, Ga., and completed his residency training in surgery at North Carolina Baptist Hospital and Bowman Gray School of Medicine, Winston-Salem, N. C. Dr. Tribble's residency program was interrupted for a two-year tour of duty as a surgeon at Otis Air Force Base, Cape Cod, Mass. For the past year Dr. Tribble has held a fellowship in cardio-vascular surgery at North Carolina Baptist Hospital and the Bowman Gray School of Medicine. He is certified by the American Board of Surgery.

Dr. Birnie Johnson, Jr. has become associated with Dr. James L. Wells in the practice of internal medicine at Orangeburg. Dr. Johnson is an honor graduate of the Medical College of South Carolina. He did his internship at the University of Virginia Hospital at Charlottesville, Va. and completed his residency in internal medicine at the University of Alabama Hospital in July, 1961. For the past year he has taught in the University of Alabama Medical School.

Dr. J. Frank Martin, a general practitioner, has opened an office at 1214 Bull Street, Columbia. He was graduated from the Medical College of South Carolina in June, 1961.

Dr. Dan R. Pace, a native of Marion, has joined the staff of the Mullins Hospital and will have private offices with Dr. Carl B. McMillan. Dr. Pace graduated from the Medical College of South Carolina in 1961 and served his internship at the Columbia City Hospital.

Dr. Julian Hard, Jr., a native of Charleston and a graduate of the Medical College of South Carolina, has moved to Bethune where he has recently opened an office.

Dr. David Glen Askins has begun the practice of medicine with Dr. James B. Berry, Jr. in Marion. Dr. Askins graduated from the Medical College of South Carolina in 1960, took his internship at the Medical College Hospital and has just completed his residency in internal medicine at the same hospital.

Dr. Strauss Is Honored At Pee Dee Medical Meeting

Dr. D. D. Strauss of Bennettsville was honored at a meeting of the Pee Dee Medical Association in July. A graduate of the Medical College of South Carolina, Class of 1912, he was presented a 50-year pin by Dr. P. M. Kinney, also of Bennettsville.

Swansea Gets Full-Time Physician

Swansea, which has been without a doctor since 1958, has at last obtained the services of a full-time physician in the person of Dr. William H. Granger. Dr. Granger, a graduate of the Medical College of South Carolina, completed his internship at Columbia Hospital just prior to settling in Swansea. He holds daily office hours in a Medical Center which the townspeople built last year in the hopes of attracting a resident physician.

Haynes to Head Naval Hospital In Beaufort

Navy Captain Lewis L. Haynes (MC) has relieved Captain Paul G. Richards (MC) as commanding officer of the U. S. Naval Hospital in Beaufort, S. C.

Capt. Haynes was formerly stationed at the U. S. Naval Hospital, Chelsea, Mass.

Industrial Medical Association

The Carolina Industrial Medical Association, component society of the national Industrial Medical Association, will have its Fall meeting at Sonoco Products Company's plant in Hartsville, South Carolina, on Saturday, October 27th. The meeting will begin at 1:30 P. M. and will conclude that evening with a social hour and dinner, doctors and wives attending being the guests of Sonoco. The program will feature a tour of Sonoco's medical facilities and discussion of medical programs in progress within this industry. The program will also include: Dr. Geo. Holt, Asheville, North Carolina, discussing "Foot Care in Industry;" Dr. W. L. Wilson, Raleigh, North Carolina, discussing "Immunizations in Industry;" and, Dr. B. M. Montgomery, Jr., Newberry, South Carolina, discussing "Hemiplegias."

All interested physicians are urged to attend and information in this regard should be directed to Dr. John Perry, Jr., Sonoco Products Co., Hartsville as soon as pissible. There will be no charges in conjunction with attendance.

MEDICAL TELEVISION

Thursday and Friday, November 1st and 2nd, 8-9:30 P. M. on South Carolina's Educational Television Network.

NEUROLOGICAL CLINIC

Parkinsonism and Convulsive Disorders

Panel

Guests

Dr. Raymond A. Adams,
Consulting Neurologist
Richmond, Virginia

Dr. George W. Smith
Prof. of Surgery and Chief of Neurosurgery
Medical College of Georgia

Moderator

Dr. Rhett Talbert, Assoc. Prof. of Neurology
Medical College of South Carolina

Supported by a grant from Merck Sharp & Dohme Postgraduate Program.

Deaths

DR. R. P. JEANES

Dr. R. P. Jeanes died suddenly of a heart attack about midnight August 1 at his home.

A native of Clinton, after graduating from Presbyterian College, he received his medical degree from the Medical College of South Carolina. He did post graduate work at the Lying-In Hospital of the University of Chicago, graduating in 1933.

In 1934 he established an office in Easley as a general practitioner, but each year continued his pursuit of a specialized practice in diseases of the Eye, Ear, Nose and Throat.

Always an active member of the American Medical Association, Dr. Jeanes was also a member of the Association of American Physicians and Surgeons, the S. C. Medical Association, and Pickens County Medical Society. He also belonged to the National Medical Foundation for Eye Care.

His professional, civic and religious activities were interrupted when he entered the Army as a first lieutenant during World War II. After five years of active duty at Camp Forrest where he served as head of the eye, ear and nose clinic, he reverted to a reserve status with the permanent rank of lieutenant colonel. During the Korean conflict he was recalled to active duty for several months.

Dr. Jeanes was a leader in his church and community.

As a committeeman of the Blue Ridge Council of the Boy Scouts of America, he had also served for four years as committeeman on the National Council, receiving the Silver Beaver award in 1947 for his outstanding service.

He was a National Council member of Boy Scouts of America, representing the Blue Ridge Council.

Other activities included an avid interest in growing camellias, and he held a life membership in the American Camellia Society.

The pursuit of collecting old firearms was perhaps instrumental in his being a charter member, vice president and director of the Carolina's Gun Collectors Association of North and South Carolina, and receiving from the club recently a silver plaque recognizing his length of service to the club.

Under Dr. Jeanes direction, the annual Hobby Show in Easley sponsored by the Lions Club, became a reality and a very significant attraction for hundreds each year.

Through his work in sight conservation and as a director of the South Carolina Eye Bank, Dr. Jeanes continually showed his concern for his community.

Will You Help Us Check Our Records?

The following list of SPEAKERS BUREAU chairmen has not been revised since 1961. Some of you have written to us to tell us of new appointments. We would like to correct the entire list. If the name of the bureau chairman of your County Society is incorrect we will appreciate a post card addressed to BOX 275, Charleston.

ANDERSON
Dr. H. J. Hancock

BARNWELL
Dr. C. C. Freeman

BEAUFORT-JASPER
Dr. Sol Neidich

CHARLESTON
Dr. Henry Heins

CHESTER
Dr. W. R. Wallace

COLUMBIA
Dr. C. Tucker Weston

DARLINGTON
Dr. George Timmons

DILLON
Dr. Thomas C. Hankins

DORCHESTER
Dr. Louis Miles

FAIRFIELD
Dr. John C. Buchanan, Jr.

FLORENCE
Dr. Albert Baroody

GEORGETOWN
Dr. James Forrester

GREENVILLE
Dr. A. G. Meakin

GREENWOOD
Dr. C. J. Scurry

KERSHAW
Dr. Charles Zemp

LANCASTER
Dr. William E. Sims, Jr.

LAURENS
Dr. J. F. Dusenberry

MARLBORO
Dr. C. A. Kinney

MARION
Dr. William L. Cheezem, Jr.

OCONEE
Dr. J. P. Booker

PICKENS
Dr. J. K. Holcombe

SUMTER-CLARENDON
Dr. Wallis Cone

WILLIAMSBURG
Dr. Keith F. Sanders

YORK
Dr. James C. Holler

Hampton County Doctors Alert Public

The following reprint, distributed by Hampton County doctors, presents the facts on medical aid for the needy. This excellent educational leaflet serves as a reminder that the tableing of the King-Anderson Bill won a battle — not a war. Similar legislation is sure to come up next year. It is vital that we continue to put the true facts before the public during the crucial fall months.

Did You Know?

The following medical aid for the Needy, whether old or not, is available in South Carolina today at public expense, from taxes already paid.

Hospital Care Now Available for the Indigent

A—Hospitalization for Public Assistance Recipients (DPW). Any persons, regardless of age, may receive 40 days free hospital care and, if needed, 90 days nursing home care, if they receive benefits under one of the following categories, provided same or better is not offered by any other agency—

(a) Old Age Assistance
(b) Aid to Needy Blind
(c) Aid to Totally and Permanently Disabled
(d) Aid to Dependent Children
(e) Recipients of general assistance plus any essential person (parent, relative or caretaker) of the above whose needs have been included in the plan

Hospital Care Now Available for the Aged

B—Medical Assistance for the Aged (Kerr-Mills Bill). Persons 65 years old or older (with or without Social Security) may receive—

(1) 42 days hospital care free
(2) 90 days (or more) nursing home care free
(3) 3 visits for each 31 days, emergency room service, organized clinic service, special diagnostic and therapeutic service (provided same or better not offered by other agencies). To be eligible a person may—
  (a) Own homestead (home and land)
  (b) Personal property such as automobile, television, household furnishings, and farm equipment.
  (c) Have $500 in savings if individual, $800 if couple.
  (d) Have cash, loan or surrender value of life insurance of $1000 if single, or a couple may have $2000
  (e) Earn up to $1000 single or $1800 for a couple per year

C—Hospitalization Available through County Funds

D—Prevention of Blindness and Restoration of Vision Program.

Medical and Hospital Care Available for Others

E—Other Medical Programs Available

(1) The State Cancer Program
(2) The State Crippled Children Program
(3) The State Heart Program
(4) The State Vocational Rehabilitation Program
(5) The National Foundation (Polio)
(6) The Veterans Administration Program
(7) The S. C. Crippled Children Society
(8) The County Cancer Society
(9) The State Tuberculosis Program
(10) The County Health Department
  (a) Well Baby Clinic
  (b) Prenatal Clinic
  (c) Venereal Disease Program
  (d) Chest x-ray
(11) Local Lions Club, Sight Conservation
(12) Teaching and Research Grants at Hospitals, (foremost at Medical College Hospital, Charleston, S. C.)
(13) Mental Hygiene Clinic
(14) Others

Medicare under Social Security pushed by the Kennedy Administration is not a plan to provide more or better medical care for the aged. It is merely a matter of refinancing it and bringing it under government control. It is purely a political move to centralize more power and control in Washington, D. C.

Olin D. Johnston would force you to pay more Social Security tax to provide "free" hospital care for President Kennedy's father and other millionaires.

Senator Strom Thurmond denounced Medicare under Social Security and voted against it. W. D. Workman has proclaimed it a deceit and a fraud.

Can you afford more taxes from your payroll check?

Doctors of Hampton County

FOUNDERS' DAY PROGRAM
MEDICAL COLLEGE

FRIDAY, NOVEMBER 2nd

Morning Session

Presiding, Dr. John May, President, Alumni Association, Medical College of South Carolina.

8:30—REGISTRATION

9:00—Greetings—Dr. H. Rawling Pratt-Thomas, President, Medical College of South Carolina.

9:10—*The Research Program of the Medical College*
Dr. Robert P. Walton

9:30—CLINICAL CONFERENCES AND DEMONSTRATIONS
Attendance at each Conference will be limited to the first 25 registrants signing up for the particular conference. Student guides will be available to conduct each group to its meeting place.

1. *Techniques in Diagnostic Radiology*
   Dr. Harold S. Pettit and Staff
   Radiology Department, 3 West, Medical College Hospital
2. *Evaluation and Treatment of the Pregnant Patient with Hypertension*
   Drs. E. J. Dennis, Forde A. McIver, Cheves McC. Smythe, and William Bradham.
   Conference Room, 8 Center, Medical College Hospital.
3. *Current Concepts in the Management of Infectious Diseases.*
   Drs. Louis P. Jervey, Jr. and John P. Manos.
   Conference Room, 6 Center, Medical College Hospital.
4. *Hematoporphyrin Fluorescence in Neoplastic Diseases.*
   Drs. Henry B. Gregorie, Jr., Travis B. Stevenson and H. Rawling Pratt-Thomas.
   Cancer Clinic Conference Room.
5. *The Recognition and Treatment of Depression.*
   Dr. Jennings J. Cleckley and Staff.
   10th Floor, Medical College Hospital.

10:45—COFFEE BREAK

11:00—COMBINED CLINICAL CONFERENCE
Endocrine Problems in Gynecology with Special Emphasis on Abnormal Vaginal Bleeding: Cause, Diagnosis, and Treatment.
MODERATOR: Dr. E. J. Dennis
All in attendance are invited to participate in the discussion.

12:30—Adjournment of Morning Session

12:45—ALUMNI LUNCHEON—Alumni Memorial House
All in attendance are invited to be the guests of the Medical College of South Carolina at the Annual Alumni Luncheon at the Alumni Memorial House on Courtenay Drive —12:45 p. m. Friday.

Afternoon Session

Presiding, Dr. Joseph H. Cutchin, President, South Carolina Chapter, American Academy of General Practice.

2:00—*The Post-gastrectomy Dumping Syndrome.*
Dr. Michael G. Weidner, Jr.

2:20—*The Present Status of Tuberculosis.*
Dr. Harry E. Walkup, Director of Research, National Tuberculosis Association—American Thoracic Society.

2:50—*Diagnosis and Treatment of Common Hemorrhagic Disorders.*
Dr. O. Whitmore Burtner, Assistant Professor of Clinical Medicine, University of Miami School of Medicine.

3:20—QUESTION PERIOD

3:30—COFFEE BREAK

3:45—CLINICAL CONFERENCES AND DEMONSTRATIONS
See morning schedule. Each Conference or Demonstration will be repeated for a new group.

5:00—Adjournment of Afternoon Session.

Evening

7:00—ANNUAL RECEPTION AND BANQUET, Alumni Association Members and Guests.
FRANCIS MARION HOTEL
(Parking available in Sears Parking Lot)
REFRESHMENTS—The Sky Terrace
DINNER—Colonial Room
Presiding—Dr. H. Rawling Pratt-Thomas
Vignette of a Founder—Henry R. Frost, M. D.
Dr. Joseph I. Waring
ADDRESS Dr. Thomas F. Jones, Jr., President, University of South Carolina

SATURDAY, NOVEMBER 3rd

Presiding, Dr. James H. Gressette, President, South Carolina Medical Association.
9:00—*Surgical Grand Rounds.*
Moderator: Dr. George H. A. Clowes, Jr.
10:00—*The Prognosis in Childhood Cancer.*
Dr. Harold W. Dargeon, Chairman (Emeritus), Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases.
10:45—COFFEE BREAK
11:00—*Clinico-Pathological Conference.*
Dr. Edward E. McKee
LUNCHEON—Available at Alumni Memorial House at 12:15 p. m. for those desiring to attend Citadel - V. M. I. Football Game.
FOOTBALL GAME: Citadel vs. Virginia Military Institute, 2:00 p. m. Municipal Stadium.
Note: A block of tickets on the East Side, near 50-yard line, has been set aside for those attending Founders' Day Seminar. Orders, accompanied by check, must be received by October 25th. Tickets may be picked up at the Registration Desk. All orders should be sent to Mrs. Sarah Hodges, Secretary, 280 Calhoun Street, Charleston, South Carolina.
Buses will be available for those desiring transportation to and from Municipal Stadium.

Acceptable for twelve hours Category I credit, American Academy of General Practice.

EXCERPTS FROM

MEDICAL SERVICES FOR HIRE — FOR SALE A DISSERTATION ON THE INALIENABLE RIGHTS OF INDIVIDUALS AND MINORITIES IN THE DEMOCRATIC FORM OF GOVERNMENT

BY
G. K. HIGGINS, M. D.
CALGARY, ALBERTA, CANADA

PRESENTED TO
AMERICAN MEDICAL ASSOCIATION
INSTITUTE
CHICAGO, ILLINOIS
AUGUST 1962

The paper deals with compulsory medical care in terms of its effect in sustaining the ideal and tenets of "Western Democracy," as understood by the author, and as a consequence of this examination in the light of these ideals and tenets, it is apparent that compulsory medical care insurance cannot sustain these ideals, but can become a major factor in their destruction.

This paper is a plea for recognition of the fact, that, in considering implementation of a plan of compulsory medical care insurance, it is not sufficient to ascertain the wishes of the majority of citizens.

If "Western Democracy" achieves compulsory medical care insurance by legislating those whose lot it would become to provide the service, into involuntary servitude, then "Western Democracy" becomes a pious fiction.

Freedom is endangered in the old Democracies of the West as government power spreads over institutions and groups that have traditionally acted as checks to the power of the State.

Even more dangerous is a diminution and emerging disregard and disrespect for certain traditionally inalienable freedoms and rights—such as freedom of contract.

Freedom of Contract

When the State offers the citizen a "free" tax supported service it must assume the duty of regulating the fee for the service as it cannot combine the responsibility of a "free" tax supported service without ultimate authority.

The State alone can levy and dispense public monies.

Thus, an act or bill, although it supposedly only appropriates money for a "free" service, can effectively control a profession, group or institution. The State must set the terms, conditions and standards governing its expenditure and decide who is qualified to receive payment and under what conditions.

There is no more effective way to exercise control than by a control of income—"He who pays the piper calls the tune." Hamilton, in #79 of the Federalist, states it another way; "In the general course of human nature, a power over a man's subsistence amounts to a power over his will."

Economic control is present whenever any agency, Government or private, becomes the sole buyer and seller of medical services or any other service in the community.

Dangers to Freedom in "Free" Tax Supported Services

Bureaucratic Government control must exist over

any "free" tax supported service and the dangers to freedom proportionately increased. For example:

If the legal profession were socialized, who would represent the individual against the State? Or if citizens enamored of a slogan—'cleanliness next to godliness'—advocated free tax supported plumbing as a right, would the Guilds and Unions agree to the principle of economic control by the State? to the principle of compulsory arbitration? to the principle of the State having power to legislate its own idea of a fair wage?

Are not some citizens in favor of "free" tax supported services with government control and compulsory arbitration—with the State having power to legislate its own point of view—but only when it applies to somebody else and not themselves.

* * * *

The Trend to Socialism

Social justice has largely been achieved by restriction of income, by progressive taxation and by collective bargaining. The more prosperous citizens and institutions are denied a portion of the fruits of their labor for the common good.

Social justice has never been attempted by reducing a group to servitude.

The State endangers freedom when it enforces servitude of minorities and institutions which deserve to be free, which should have freedom of contract, which should not be exploited by the State. There is grave danger that modern states are hiding political expediency under the name if social justice.

* * * *

If professions and institutions are forced to sell their labor and services to the State in order to subsist, freedom becomes a pious fiction.

Free men and institutions have the right to place a value on their labor and services, and these freedoms are endangered when the State promises the people the "free" tax supported services of others with the known opposition of those individuals and institutions whose duty it would be to provide the services.

There would be general agreement that free essential services should be provided for the deserving needy, and there should be agreement that it would be entirely proper to grant more generous benefits to those in need than to grant equal benefits to all regardless of need.

It must be appreciated we always have had and always will have the more numerous poor.

It must also be realized the aim of political parties is to gain the more numerous vote.

It would seem logically to follow to win elections one is tempted to please the many at the expense of the few—the majority at the expense of the minority.

The trend to the Welfare State is thus not surprising.

It would also seem to logically follow that the trend of increasing State power and bureaucratic tyranny cannot be halted by an appeal to the people solely in economic principles. It can only be halted by those whose freedom is endangered.

The trend of ever increasing government power and bureaucratic control can be halted only if the groups historically responsible for individual freedom and liberty—have the conviction and courage to fight for their rights. It was from such conviction and courage that freedom and liberty emerged and it will only be by similar convictions that freedom and liberty will be sustained.

Rights and Duties

The advocates of the welfare state and socialized medicine in particular, have adopted the slogan "medical care as a right" and would demand medical care as a right.

It is opportune to analyze and study the implications and possible consequences of this demand. This will be initiated by quoting excerpts from Sir John Salmond's classic work "Jurisprudence."

"A moral or natural right is an interest recognized and protected by a rule of natural justice—an interest the violation of which would be a moral wrong, and respect for which is a moral duty . . . .

"If there are no rights save those which the State creates, it logically follows that nothing is right and nothing is wrong save that which the State establishes and declares as such."

Citizens, then, have a moral right to medical care, if needed, and physicians a moral duty, if requested, to provide that care. A correlative moral and ethical relationship which has existed from ancient times.

"A legal right," Salmond continues, "on the other hand, is an interest recognized and protected by a rule of legal justice—An interest the violation of which would be a legal wrong to him whose interest it is, and respect for which is a legal duty."

* * * *

Medical Care As A Right

Medical care as "a right" will now be examined.

As mentioned earlier it is generally accepted that the citizen has a moral right to medical care and the physician a moral duty to provide it.

In a democratic society the *legal* claim to this right is valid only under certain circumstances. Medical care as a legal right should not infringe upon or require the sacrifice of other legal or moral rights, such as those contained in the Constitution of the United States of America or the tradition of personal freedom and liberty in Canada.

If the State assumes the duty of providing medical care, this duty can be discharged only through the medical profession.

* * * *

The Physician then—by law—has the duty to provide the medical care.

The State has the duty to pay for the medical care. The State's correlative right—to levy and collect tax monies.

* * * *

Mr. Enoch Powell, British Minister of Health, is quoted from his Lloyd Robert's Lecture to the Royal Society of Medicine (BMJ October 28, 1961, p. 1136): "The expenditures on this country's public financed health services over the next 3 or 4 years will, it is intended, be allowed to rise in total at a

rate not exceeding about 2½% per annum."

From Hamilton BMJ January 23, 1960: "I have referred to the unhappy need for the profession (in Britain) to bicker and bargain for its remuneration with the state, which in practical terms means the permanent officials of the Departments of State. We are all acutely aware that when the professions last claim was presented, negotiations upon it was denied. Indeed, the profession was cynically told the claim, and the close arguments in its support, were not even examined. Arbitration upon it was denied, as was even recourse to the courts. "What the officials think is right is what goes."

"Thus, if the physician agrees to provide medical care in a "free" tax supported service he can only do so by relinquishing freedom of contract, i.e. the right to bargain for his labor and services,—and his liberty as an individual.

If the physician does not agree to relinquish such a basic freedom and the State compels the physician to provide the medical service by threats, coercion and legislation, it does so by an abrogation of liberty and an imposition of servitude.

Thus, the State, if it assumes the duty of providing medical care, disregards the objections of a minority group whose lot it would become to provide the care. The State can only discharge its duty by abrogating the most essential element of individual freedom and thus of democracy, *freedom from involuntary servitude.*

Medical care can become a legal right if physicians accept or are legislated into servitude.

To establish medical care as a legal right will be necessary either:

(a) for the physicians to abrogate their freedom of contract, or

(b) for the State to impose upon the physicians involuntary servitude.

* * * *

While Canadians have always considered tradition as effective as any formal declaration of rights, recent threats to these rights have evolved, for example.

—When government has interfered with individual liberty and the right of contract, as in Saskatchewan, by attempting to impose civil conscription of the medical profession.

—When politicians and political parties are daily promising people the "free" services of others, with the known opposition of those whose duty it would become to provide the service.

It is now necessary in Canada to have these traditional freedoms formally guaranteed by constitutional authority under the rule of law and in America may I suggest it would seem prudent to evaluate all threats to individual freedom and liberty against the guarantee of inalienable rights, which protect individuals and minorities in your Constitution.

Such an approach ensured the freedom of the profession in Australia.

Civil Conscription

A compulsory state medical care plan was declared illegal in Australia on the basis that it abrogated fundamental rights defined in the Australian Constitution.

* * * *

The Basic and Fundamental Argument Against Compulsory State Medical Care

The basic argument against compulsory state medicine is that it abrogates the rights of those receiving the care and more especially those providing the care.

* * * *

It is indeed incongruous that citizens who have striven centuries for the right to bargain for their services would now propose to abrogate the right of a minority group to bargain for theirs.

May I respectfully suggest that the profession in the United States of America should make clear that in its criticism of and resistance to compulsory state medicine, it is merely acting in the fore-front for the moment of the battle carried on for centuries by all Americans to ensure the continuance of those inalienable rights granted to American citizens in the Declaration of Independence and in the Fifth (5th) and Thirteenth (13th) Amendments to the Constitution. The important thing for the profession to bear in mind and to make others realize is that in criticizing and resisting within the frame work of your constitution a compulsory medical care plan, you are acting with an identity of purpose to all who in your country uphold to the full the famous words from your Declaration of Independence:

> "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness."

Your concern is to ensure in the words of Article 13 of your Constitution that:

> "neither slavery *nor involuntary servitude,* except as a punishment for crime whereof the party shall have been duly convicted shall exist within the United States or any place subject to their jurisdiction."

To base your cause on your inalienable rights and your freedom from involuntary servitude will emphasize the fundamental and basic nature of the threat to liberty and bring it into a proper perspective. The fundamental moral and legal issue in the controversy over universal compulsory health services, controlled and operated by the State, is not the issue of goodness or badness of ends.

Epilogue

If, in a Democracy there is *any diminution* in respect for the tradition of personal liberty, and if personal liberty is not guaranteed by Law, individuals and minority groups are vulnerable to involuntary servitude to the state and to exploitation by the State.

The minority group is placed in a dilemna;

1. If it resists, as natural justice demands, it transgresses its own ethical and moral laws,

2. If it submits, it surrenders a natural right of man—freedom from involuntary servitude.

MEDICAL MANAGEMENT OF THE NURSING HOME PATIENT

MARTIN B. WOODWARD, M. D.

Columbia, S. C.

I am no authority on nursing homes; however, I have been House Physician at Hartford Nursing Home for 3 years. We have 105 colored patients, all with exception of 2 or 3 are welfare recipients. I must give credit to M. H. Baxley for his efforts. He is a credit to his race. He could give lessons to an economist. For $58 a month he feeds, clothes, houses, gives medical care and furnishes medication to all of his patients. Granted, our nursing home is not one of the best; however, it provides care for these people that they would not ordinarily get. We certainly need more nursing homes, because our population is aging and the aged are becoming more numerous.

I would like first to speak about the classification of nursing homes as presently defined here in South Carolina and what we need. The already excellent classification used now by the State Health Department needs supplementing. It is not fair to submit patients to care without proper facilities nor is it fair to the doctor or community. I have formed a classification of my own entirely independently of the classification that is currently proposed by the American Nursing Home Association. My classification parallels this exactly; terminology is somewhat different, but it is the same idea. Supplementing the present regulations with this and other minor changes would, I think, improve our standards.

I have four classifications of nursing homes, and I propose these to the State Health Department as a permanent classification.

My first classification is that of "Boarding Home." The American Nursing Home Association (ANHA) has classified this as a "Supervised Living Care Facility." A Boarding Home, in my opinion, should be only for domiciliary care, which should apply to the patient the basic needs for life under adequate medical supervision; such as treatment for colds, prescribing vitamins, those things that just normal people need every day. The Boarding Home should be so organized as to refer acute illnesses and more advanced problems to the proper facility for their care. A boarding home may be run with licensed practical nurses and should be designed for long term care.

The second classification I have proposed is that of a "Nursing Home." The ANHA entitles this a "Skilled Nursing Care Facility." This classification of home should care for chronic, non-infectious diseases requiring more specialized nursing care than that of a boarding home, such as hypertensive cardio-vascular disease and its complications, moderately advanced diabetes, moderately advanced cancer, and diseases of such nature. It, of course, should be a long term care facility, and it should be supervised by a graduate nurse supervisor.

The third classification I have is that of a "Convalescent Home", and the ANHA classification is entitled "Intermediate Nursing Care Facility." The convalescent home should be devoted to short term confinement of three months or less, to those patients who are convalescing from operative procedures or who have acute diseases not requiring hospitalization. These homes should have a graduate nurse on each shift and properly licensed practical nurses and other facilities for intensive nursing care, very similar to that of a hospital.

The fourth classification is that of a "General Nursing Hospital." The ANHA entitles this an "Intensive Nursing Care Facility." This facility should be in no way different from a general hospital. It should be equipped with everything that is needed in a general hospital except operating room facilities, and should have adequately trained personnel.

This classification will certainly hurt some of the nursing homes that we have; others, it will help. But I certainly think it is a simple enough classification that can be adequately utilized, and it is something that should be implemented to clarify the confusion now existing as to the type patients that should be admitted to each home and to improve South Carolina's care of the aged today.

It is rather frustrating to a physician to receive a patient who can neither talk nor gesticulate, or in any manner convey to the physician what is wrong with him. And, very frequently, such patients are admitted to the nursing home at which I work. There should be certain definite medical care given to the patient prior to admission to any nursing home. This could be supplemented in the present licensure manual of the South Carolina State Board of Health. This then is my suggestion for regulations ruling admissions to nursing homes:

1. There should be an adequate past history, recording of the present condition, a diagnosis and the treatment that is anticipated for that patient by the referring facility, whether it be a welfare organization, a private physician or a hospital.
2. The patient should have a chest x-ray film which can be obtained free or at a nominal cost in any of the County Health Departments. The x-ray will help rule out such infectious diseases as tuberculosis, chronic diseases such as cancer, chronic lung disease and other diseases that should be known about by the Nursing Home Physician.

Read at the Institute on Improvement of Patient Care in Nursing Homes, Columbia, S. C., September 19, 1961.

3. A Wasserman and Kline, or a comparable test, should be done to rule out syphillis.
4. Two optional tests probably should be done, and I will mention these tests later on. A two-hour post-prandial blood sugar to help rule out diabetes and
5. A blood urea nitrogen determination to evaluate the state of renal function.

These last two tests in aging people are important in my estimation; however, they may be optional prior to admission. Personally, I would prefer that they be required. These five things would greatly help the Nursing Home Physician.

Contrary to many opinions, a nursing home can have a very adequate laboratory that can do all of the basic tests that need be done for patients in a nursing facility. You may not believe it, but a laboratory in a nursing home can be set up for as little as $125. With the development of new techniques in laboratory procedures, kits are being made now to give the physician accurate (and by accurate I mean between one and ten per cent accuracy) tests that are comparable to acceptable tests now being done in commercial laboratories. The things I am going to enumerate now can be obtained for approximately $125. The Hartford Nursing Home recently bought a microscope. It is not pretty, it is about 50 or 75 years old, but it works—it cost $50. They are hard to find, but occasionally you may find one. Of course microscopes run any where, new, from $500 to $1,000, depending on choice. However, you may get used ones for much less. The Ames Company puts out a kit for blood sugar called Dextro Test; it costs about $5. It has thirty tests in it and refills can be obtained for about $4. It costs 17¢ a test. I think commercial laboratories charge $3. This test is a cook-book procedure. You put a tablet in the drawn blood, filter it through filter paper, put another tablet in the filtrate and compare it with a color chart. It is approximately 10% accurate. A third item is a urograph kit. This kit is manufactured by Warner-Chilcot, and it costs about $18. It has been checked out as being accurate to within 1% in giving blood urea nitrogen values, which, as I mentioned previously, would help evaluate the function of the renal system. It costs about 18¢ a test. For doing urinalyses, the equipment will cost about $10; slides, droppers, Uristix for testing urine sugar and albumin (you just dip a chemically treated paper into the urine and compare it with a color slide.), and Acestix for testing the amount of acetone in the urine. The physician of the nursing home can do a microscopic examination of the urine in about two minutes. A hemoglobinometer can be obtained for about $12, for $15 you can have a blood counting chamber added to that, pipettes cost about $1.25 each. A doctor can do a blood count in about three to five minutes. A hemoglobin reading will cost you probably 10¢, a blood count a little bit more, $1 or $2. Commercial laboratories charge $2 or $3 for urinalysis and $3 or $5 for a blood count. You can obtain material in either little sticks (cardboard sticks impregnated with a chemical) or tablets to detect blood in the urine or the stool. These cost $1 or $2.

All of these tests I have enumerated (except the microscopic urinalysis and WBC and differential) can be done by anybody with an I. Q. of 90, and most maids have an I. Q. of that much. Surely all practical nurses should be able to master these with a short course of instruction. They are cookbook procedures, and if the person doing the test is not color blind, the tests are accurate.

The things that I have enumerated, microscope, Dextro test, urograph, material for urinalysis, hemoglobin (and blood count if wanted) material for checking blood in the urine and stool should be basic in every Nursing Facility. It is certainly much cheaper to the patient than having a commercial laboratory do it.

What are the responsibilities of a nursing facility to the doctor and to the patient? The following is a list of things that I have put down from my experience and from suggestions from numerous people. The following items would supplement our existing regulations.

1. Adequately trained employees. I have put down a rough classification according to size of the nursing facility and this, in conjunction with the previous classification I have given about types of nursing homes should dictate what type or how adequately trained your employees should be. I think that a nursing facility with 25 beds or less should have one graduate nurse supervisor; with 25-50 beds they should have a graduate nurse supervisor and one graduate nurse on the second shift; with 50-75 beds, a graduate nurse supervisor and one graduate nurse on each shift; with 75-100 beds or more, I think they should have a graduate nurse supervisor, one graduate nurse and one licensed practical nurse on each shift.

   In my opinion, these are minimum standards for adequate medical care. When you have 100 patients, it just takes a lot of care. We have 100 patients at Hartford, and we have one graduate nurse and several maids. It is not at all adequate, but they do a fair job with what they have to work.
2. I think that a basic laboratory should be available to the physician. This was outlined before.
3. There should be an adequate dietary facility. The State Health Department has a dietitian who will consult with you. We have had the dietitian at Hartford, and she has helped a great deal. A nursing home that has over 100 patients should have a dietitian employed full time. Diets are extremely important in the aged, because of vitamin deficiencies due to dietary idiosyncracies, improper function of aging organs where food substances are not assimilated correctly, and, of course, diets are a major portion of the treatment of some illnesses such as diabetes and many others. I think it is extremely important that the

dietary portion of the care of the nursing home patients should be adequately supervised. Supervision is furnished to you at no cost, and you may avail yourself of it at all times.

4. I will briefly mention records. This will be covered in detail later in the program. As far as the responsibility of the nursing home to the doctor and the patient goes, adequate records should be maintained that tell you:
   A. The work that has been done for the patient (It need not be professional; all you have to know is what has been done).
   B. A list of the medications that have been given and the time given.
   C. The course of the patient in the doctor's absence.

   These 3 simple things should be recorded for the doctor and for the benefit of the patient. I think, of course, that a boarding home will require much less detailed recording of these things than would a more advanced nursing facility. All records should be stored properly so that they may be obtained for reference to a present case, any future treatment by another facility or physician, or any legal action that comes up.

A physician may be hired on many bases: a fee-for-service basis, a monthly retainer, a salary plus a fee-for-service, etc. I think most physicians will work with you any way you wish.

The nursing home should have a nurse available for the physician when he makes rounds—that goes without saying.

The nursing supervisor in a nursing home should know her patients, and she should be able to know enough about the patients to apprize the physician of any psychological or physical change that she thinks requires medical attention. Physicians in nursing homes frequently do not make visits as regularly as they do to acutely ill patients, and it is up to the nursing facility, medically and legally, to have adequately trained personnel that will recognize these changes and apprize the doctor of the situation.

I think that the nursing home should have a set of rules and regulations just as hospitals do and enforce these rules and regulations, and I am including my own profession. In all of the hospitals here in Columbia, when a physician does not meet the required specifications for rules and regulations, he is suspended from admitting patients to that hospital until he complies with these regulations. I think this should certainly carry through to nursing homes. That will immeasurably raise the standards, and the doctors will appreciate your concern for the patient. Unfortunately, some doctors, including myself, not through choice at all but from duties that require a lot of time, sometimes do not comply with all regulations.

What are the responsibilities of the physician to the nursing home and to the patient? First, a physician should be available or have a competent substitute on call at all times. This is required by law in South Carolina. The physician should perform an entrance examination in addition to that done by the referring facility, and record this and give the diagnosis. He should write or dictate to the nurse in charge (and in most places, Columbia Hospital I know, dictation to the supervisory nurse is considered to be in writing) adequate and detailed orders.

Now, what are these detailed orders? First, the type care, whether it be domiciliary care, basic nursing care such as helping with baths, dressing, shaving, etc., or advanced nursing care which includes the first two plus specific care needed and spelled out.

Second, the type diet that the patient should have whether it be soft, low fat, diabetic or what have you; third, the basic medications that the patient should have such as vitamins and sleeping pills, etc., fourth, special medication, antibiotics, insulin or other medications of a special nature; fifth, any special treatment such as physio-therapy or speech therapy. And the doctor is required to sign or initial all orders. This has its legal ramifications. The doctor should make a periodic check on all the patients in the nursing home that he is responsible for and make a progress report on the charts of the patient's progress. At Hartford, I make grand rounds every three months, every quarter, and I put something on the chart even if it is just "O.K." and apprize myself of that patient's condition, whether the medication needs changing, whether the patient needs specialized care or other attention. Of course I visit the nursing home when called for acutely ill patients, treat them or refer them to the proper facility. And last, the doctor should promptly complete all the records on the discharge of the patient.

What are the responsibilities of the community to the doctor to the nursing home and to the patient? I am speaking now primarily of the State Health Department, which is the people's representative. First the Health Department should classify the nursing home by licensure. They should be classified both as to the aspect of care and personnel required, the number of nurses for each size and type nursing home, the laboratory standards should be enumerated, and the regulations for physicians should be listed according to the type of nursing home and number of beds. The requirements and standards for the records should be set out in detail. The admission requirements should be outlined. This next could carry a discussion all by itself, but I think more stringent welfare requirements should be made; our friends in New York are doing that; and all this should be added to our present fine Nursing Home Manual. I think secondly, that the State Health Department should enforce the regulations by supervision. (It is grossly understaffed. There are two inspectors for the State of South Carolina who are responsible for all hospitals and all the nursing homes.) Certainly, they just cannot get around, and it is a sad commentary on South Carolina that they will not give us any more inspectors. These people amaze me with the proficiency with which they work now. If the regulations are not

met, then the licensed facility should have its license forfeited.

I will mention briefly some of the problem cases that I encounter to point up the need for proper classification, primarily. Quadriplegia and paraplegics are certainly patients who are nursing home problems; however, they require advanced and specialized nursing care, and they should not be relegated to a boarding home. They need to be in a nursing hospital. Uncontrollable mental patients should be in mental hospitals. Severe diabetics with complications or diabetics that are uncontrollable should not be relegated to a boarding home, they need more specialized nursing care. Terminal cancer requires a lot of time and effort on the part of the nurses. Those diseases requiring expensive medication are a problem to everyone concerned. I believe that welfare patients are furnished some medication, anyhow.

Summary

In summary then, I have emphasized several things. First the classification of nursing homes; the need for medical care prior to admission to nursing homes; the need for basic laboratory requirements, the responsibilities of the nursing home to the physician and to the patient; the responsibilities of the physician to the nursing home, to the patient; the responsibilities of the community to the nursing home, to the physician and to the patient, and I have enumerated several types of problem cases.

ADDENDUM

If at any time it has appeared in this paper that criticism is being made of the South Carolina State Health Department License Division, it has not been the intention of the speaker. We have in South Carolina one of the finest Health Departments in the nation, and the manual on licensure has been recognized as a progressive one and has been used by other State Health Departments as a model. It has been the intention of the speaker; however, to suggest a few ways to improve the already excellent set of rules and regulations to benefit the people of South Carolina.

2800 Rosewood Drive

MODERN CONCEPTS OF HOSPITAL ADMINISTRATION. Edited by Joseph Karlton Owen, Ph.D., with coordinative assistance of Robert K. Eisleben, M.A. W. B. Saunders Company, Philadelphia and London, 1962. Price $16.00.

In the foreword of this volume, Dr. G. Harvey Agnew says, "This work is not so much an analysis of administrative procedures, department by department, but rather a broad study of numerous factors. Many of these are outside of the hospital, but they have a definite influence on its operation."

Dr. Owen, with an Editorial Board of 39 and a contributing staff of 72 specialists in the medical and hospital fields, has compiled a volume that lives up to the purpose as stated in the foreword.

With the complexity of the modern hospital operation and the changes being made in patient care in the hospital, it is necessary not only for the hospital administrator but for the medical profession as a whole to be aware of the present and future scope of hospital operations.

Of particular interest to the medical profession are chapters 15 through 24 which deal with the organized Medical Staff and the various departments of the Staff.

This volume is highly recommended to the hospital administrator and the doctor who is now or will be an officer of a hospital medical staff.

James R. Binder
Greenville General Hospital



SOUTH CAROLINA MEDICAL ASSOCIATION
MINUTES OF THE
ONE HUNDRED FOURTEENTH ANNUAL SESSION
OF THE HOUSE OF DELEGATES

OCEAN FOREST HOTEL **MYRTLE BEACH, S. C.**

WEDNESDAY, May 9, 1962 11 A. M.
DR. WYATT, PRESIDENT, Presiding
(MINUTES CONTINUED)

Gentlemen, will the delegates resume their seats. Gentlemen as we go into the final session of the House of Delegates, I would like to express my sincere appreciation for the cooperation you have given us so far in the sessions. I think Council, and all of the committees have functioned very nicely indeed and it has been a pleasure to rule over this House, if you want to call it that, or preside over it. You have been very cordial and I wish to express my thanks for what you have done to make the meeting go off on time.

At this time I would like to introduce Mr. Tom Hindricks, assistant to the Executive Vice-President of A.M.A., Dr. Blasingame. Dr. Tommy, Mr. Tommy? (Applause.)

MR. HINDRICKS: Dr. Wyatt, gentlemen, this grand strand is certainly a wonderful view to me after spending last week on the banks of the Potomac, and if you have read anything lately in the paper, all "isn't so quiet along the Potomac" these days.

Now, it is really a great thrill and a pleasure for me to be here today at your 114th Medical meeting, and I come here as bringing greetings from Dr. Blasingame, the Executive Vice-President of the American Medical Association and Dr. Leonard Larson, the President of the American Medical Association. And although Dr. Wyatt almost called me "doctor" the only degree I really have is an ABB degree, Assistant to Bing Blasingame. You know, I am sort of at home down here because I come from Indiana and am a southern Hoosier, and in addition to being a southern Hoosier I am an honorary member of the Princeton Greys. Now the Princeton Greys is a julep and marching society that comes out in full regalia with a kind of battle flag of the Confederacy at the time of the annual review of the ROTC at Princeton University, and they have the motto, instead of "only destructing Yankees" they have changed it to "only destructing Yales." Every year I send out Christmas cards, and last year I sent out a card that went something like this "Merry Christmas, don't feel sad, keep your upper lip quite taut, maybe it won't be as bad as Mr. Harry Trueman thought. It's true he is young, a "Soapy" fan beholden to Sinatra's clan, but how much worse the grisly tale if Kennedy had gone to Yale."

Now, I have a letter here from Dr. Larson, addressed to your president, Dr. Wyatt and if I may I would like to read this letter at this time.

"Dear Dr. Wyatt:

It is a pleasure to extend greetings to the officers and members of the South Carolina Medical Association who are gathered for their 114th Annual Meeting. I wish I could be with you, particularly to pay tribute to my good friend and fellow physician, Dr. Julian Price.

It has been my good fortune, throughout the years, to have known and to have worked closely with Doctor Price. In those days many years ago when he attended numerous AMA functions as an editor and officer from his state society, and I was Secretary of the North Dakota State Medical Association, it didn't take me long to sense that there was not a great deal of difference between the thinking of South Carolina and North Dakota on basic medical principles.

Later, we served together on the Board of Trustees. Julian served two years as Vice Chairman of the Board before succeeding me as Chairman. He brought to the Board and the American Medical Association, a great and varied fund of information and the ability to use this background in many practical ways. He was a member of the joint Commission of Accreditation of Hospitals, and one of the organizers of the Aces & Deuces Society. He spearheaded the AMA participation in the polio vaccine campaigns.

Julian has represented the AMA at many important meetings. He was the guest speaker on behalf of the profession at the Annual Meeting of the American Hospital Association in 1957. His talk at that time, "The Health of the Nation," was widely quoted, and this talk was later distributed in pamphlet form throughout the country.

His original views enabled him to bring new light on many subjects in the field of pediatrics, public health and education. His accomplishments on behalf of the American Medical Association and the medical profession have been many, and will be long remembered.

Sincerely,
Signed—Leonard W. Larson, M. D."
President, American Medical Association.

I only want to say this, it is wonderful here to meet so many friends, Dr. Wyatt, and your delegates to the A.M.A., Dr. Johnson, Dr. Cain and Dr. Weston, and Dr. Owens and at the meeting at the White House, recently, one of the very wonderful happenings was the fact that South South Carolina was the first state to send a message to Dr. Larson and here is the way the message came to Dr. Larson, from Lucy, Secretary to Dr. Lester (Dr. Lester is the head of the Washington Office of the American Medical Association) "Dr. Gressette of South Carolina called to extend best wishes to you and the group on behalf of himself and the South Carolina people."

You know, I don't think it is Potomac fever any more, it is rose garden fever, where you catch it, and it is pretty very much of an affair and you get it right back of the White House and I would say that this was pretty exciting all the way through and sometime, maybe before this meeting is over, some of you may want a blow by blow account on that, and if you do I will be glad to give it to you as I saw it, as a newspaper man, sort of hanging in on the outside of the fence looking in at the meeting. In the meantime, I would say that the outcome is no runs, no hits, no errors and definitely the American Medical Association was invited to the White House; we didn't ask for the meeting, and secondly, there was no give-in at all in the position of the American Medical Association. (Applause) If Dr. Wyatt—I don't want to take too much time but sometime if you want, I will be glad to talk about that, I know that you have much to do.

(Mr. Hindricks closed his talk with a piece of poetry he had written called "Blame it on the A.M.A.")
(Applause)

THE CHAIR: Thank you Tom Hindricks, very much. I called him Doctor a while ago, I have known him a great many years and he has been around the A.M.A. so long it is easy to get him confused.

At this time, gentlemen, if you bear with me I want to call on Mr. Parrish, Mr. John Parrish, Secretary and Vice-Pres. of the Saint Paul Fire & Marine Insurance Co., who handles the liability insurance for the state Medical Association, Mr. Parrish.

MR. PARRISH: Thank you, Dr. Wyatt, I consider this a privilege to be here. I am not going to have an opportunity to tell a single joke or read a poem or anything, but I want to bring you a short message about your program. This is your elected plan. There is a law in most states about bringing care advertising to the attention of the public. I believe in that, however, I believe you are entitled to know some of the things that are taking place and what you should do about it. I suppose you probably read in yesterday's paper or day before about a judgment rendered against a member of your profession by a jury in Florida against a South Carolinian for over a hundred thousand dollars, It is serious.

Last week, we in Saint Paul won a case for an anaesthesiologist who had been charged with malpractice. That case involved over $600,000.00. These things are still growing and that is why I think it important that we keep them in mind.

I promised your president and Jack Meadors I wouldn't talk any more than six minutes and that is all I am going to use, but I hope that it will be important to you.

In July 1959 your insurance committee completed arrangements for an approved professional program for your members through our company in Saint Paul, Minnesota. We have been in the business a great many years and have had a lot of experience and that was one of the things that brought it about. The fact that other insurance carriers are involved in your insurance committee's deliberation is sufficient indication that care was exercised in going in a company, which under the circumstances appeared to offer the best professional program which had come to their attention.

The plan and the approval of it does not involve any discriminatory feeling against any other company or program of any other company. We in Saint Paul wouldn't want that and neither would you here. It is not unreasonable, however, for us to expect that your membership will, of course, keep in mind this program which was designed and developed and approved for your particular use and I can assure you that it won't succeed unless participation by a substantial number of members is obtained. One thing you are looking for and we are looking for is constantly improved rates, constantly improved markets and that is your objective among other things. The purpose of the program in the mind of your committee and your officers was to stabilize the vacillating malpractice market. You, who are in the profession need no example to illustrate the tremendous number of claims which are taking place all over the country. California is the best example of that and you are lucky back here. All your periodicals, your newspapers, and other communication media keep you well-informed on matters of this kind. At the outset, the program had no rate deviation from the norm since it was the plan of the Association to earn whatever improvement they got. South Carolina rates for doctors are among the lowest in the country. You are a fortunate group of men and for good reason, we believe in the last three years we contributed to this desirable situation and it had a stabilizing effect on the market, and upon the rates and on the improvement of the form that you use. The form that you have still is not quite as broad as that your committee approved and I hope you keep that in mind.

Now there are some of the things which I would like to call to your attention, which involve this program, they are somewhat as follows: Remember the experience of the company which has a strong financial backing; it is almost as old as the South Carolina Medical Association, not quite, we are 107 years old. We have been in the doctor's professional business for a great many years, we offer a specalized form which was designed many years ago in conjunction with the American College of Physicians and Surgeons; the opportunity is yours to improve your own rates by your own participation. You have many resourceful and capable agents representing the company throughout the state with whom you can make contact and receive information concerning the program. We have experienced attorneys who are trying cases which we have had; periodic review of experience is yours for the asking. Your committee has anything available which they want at any time. Publications of articles are available and we have even gone so far as to develop moving pictures and other visual educational media which describe the pitfalls which doctors have fallen into in other areas of the country and which would be somewhat of a guard for you in your own practice in this locality.

Now, this is your program, it is jointly administered by your insurance committee, by your executive secretary and the company. It is not just simply a company plan. I wonder if you realize you have a contract available here with only one exclusion and that is pertaining to workman's compensation and that is statutory; you can't do anything about it.

Do you know that with other insurance companies we rate an anesthetist in the same fashion that we do physicians instead of surgeons, which is done by most other companies in most other areas; now this is a substantial rate-saving for those in that branch of the profession. We have reduced rates for other branches which were filed particularly for South Carolina and approved by the Insurance Department. We have many other advantages and your Saint Paul agent can tell you where the insurance advantages and where the gains are and we suggest and hope that you will listen to any of these representatives that might call upon you or any messages that may come up in your Association in connection with this.

These films, which we have made available, should be used in your county meetings, they could be used in your own office or clinic, one is entitled "Sorry Doctor," the other is entitled "Careful, doctor," they are all films which were developed from actual cases which we have collected all over the United States. We operate in every state in the union. We operate overseas and so it is a world wide situation. These are invaluable—they are available together with a film which we call "Diagnosis Danger" which is used world-wide in hospitals and other medical institutions.

I want to emphasize that this program which you have in South Carolina has been adopted in many states and in almost everyone, with the exception of South Carolina, and that is why I am bringing this emphatically to your attention, there has been substantial rate reductions. In Minnesota, alone, there have been seven rate reductions in seven years since the advent of that program and I might mention before the institution of that program Minnesota had the third highest rate in the nation, only exceeded by California and New York. Those states in which this program is really participated in actively are North Carolina, Washington, D. C., Maryland, Georgia, Rhode Island, Oklahoma, Minnesota, Mississippi, Lou-

isiana and a number of others, Indiana, included. One of the many features for your benefit is making this plan function through your local insurance representative. These are experienced men and I would hope, and I am sure that your council and your insurance committee will concur, that when our representative calls upon you you will give him an opportunity to explain what we have in detail. You are going to be called upon, you might as well expect it.

I appreciate these few minutes to bring this, which I consider an important message on a very important subject to your attention. Thank you.

THE CHAIR: Gentlemen, if I may, the Attorney General of South Carolina is here, Mr. McLeod is here at the hotel and since we had a problem concerning the dual office holding of two members of the State Board of Medical Examiners, I am going to ask him if we can get him in here and give us an opinion on this situation, Mr. McLeod?

THE CHAIR: Dr. Eaddy, will you come here please. (Dr. Eaddy comes to the rostrum.) Dr. Brewer, will you come up, please. (Dr. Brewer comes on the rostrum.)

THE CHAIR: Gentlemen, I introduce to you Mr. Dan McLeod, Attorney General of South Carolina.

MR. DANIEL McLEOD: Thank you gentlemen, I just happened to be by the hotel this morning, I didn't realize I would be involved in a legal controversy. The matter has been presented to me with respect to dual office holding. That is a very tough nut to crack, legally. Insofar as the Board of Medical Examiners is concerned there is no question whatever that any member of the Board of Medical Examiners is an officer, within the meaning of the constitutional provision that prohibits dual office holding. Now, insofar as any other office is concerned, it is difficult in any given instance to say flatly whether a particular office or position is an office within the meaning of the Constitution or is, by contradistinction, an employment.

There are various factors involved, as Mr. Meadors is well aware of, and there is no criterion that will fit any particular case. Now, Dr. Wilkinson called me on the telephone a couple of days ago and asked me about the status of one who holds the position of County Health Officer. I expressed the opinion then that tentatively that is an office, within the meaning of the Constitution, therefore you can not, if I am correct in that, and as I say I want to re-emphasize that it is a tentative opinion.

I called my office this morning after I had this question presented to me and they did find that in 1947 my predecessor, Mr. Callison, had ruled with respect to the County Health Officers with respect to the counties of Edgefield and McCormick, that they were officers in that position and therefore could not occupy another office at the same time. The other officer happened to be a member of the board of trustees of a school district.

What I am leading up to is this, I believe that a County Health Officer is an officer within the meaning of the Constitutional provision. What follows on that is that, if you hold one office and accept another office in law the effect is to cause the vacating of the office which you first held. Now, by vacancy I do not mean to physically vacate the office—they have held that even though you are a dual office holder you are entitled to the salary of the offices which you hold, even if you are a dual office holder everything that you do, whether you are legally holding one office or holding another office in a de facto status, the acts you are doing and performing in each of those offices are valid and legal in all respects. For instance, orders can be issued, deeds can be executed and documents executed, etc.; it does not affect the validity of the actual doings of one who may in fact be a dual office holder. With that in mind, if a person occupies what I think would be an office and subsequently assumed office as a member of the Board of Medical Examiners or a member of a school district board of trustees, or anything of that nature, he holds legally the last office he accepts. He holds in what we call a de facto status the first office which he formerly held; he is holding two offices.

Now it all boils down to this, and this is what I had reference to a moment ago that when some of the officers, who are now members of the Board of Medical Examiners are about to assume office, as such. Inquiry was made to my predecessor who advised that it would be proper for them to assume office as a Member of the Board of Medical Examiners. We don't have the correspondence in the short time that the secretary was able to search; she could not find the documentation with respect to that.

It is my view, that whether a person is dual office holding or not, if he assumed office as a member of the Board of Medical Examiners last, he is legally a member of the Board of Medical Examiners; in any event, he holds it in a de facto status; his words, his actions and doings are valid and proper in all legal respects.

THE CHAIR: Are there any questions? (There were none) Thank you very much Mr. McLeod.

THE CHAIR: At this time, gentlemen, council has a resolution to introduce before this delegation. As you know resolutions can be introduced before the House of Delegates from Council or by a two-thirds vote of the delegates. Dr. Brewer, Chairman of Council, you have the Floor.

DR. JOHN BREWER: Dr. Wyatt, Members of the South Carolina Medical Association, there is one thing that I think we all are vitally interested in and that is the training of our young people, our children. This resolution is adopted by council on its session this morning and it is being brought to you at this time.

Whereas, Miss Dorothy Ratliff has served as Head of the English Department of Chesterfield High School for many years, and

Whereas, Miss Ratliff's students in the past few years have won, respectively, state runner-up, state winner, and this year, national winner of the Essay Contest, Now, Therefore

Be It Resolved, that the South Carolina Medical Association congratulate Miss Ratliff for her excellence in teaching, not only basic grammar, but also ideas and ideals which have made this country great, and

Be It Further Resolved, that the members of the South Carolina Medical Association, here assembled, pay tribute to Miss Ratliff by a rising vote of sincere thanks and best wishes for her continued superior teaching." Thank you. (Applause)

(Motion was made that the resolution be adopted, this was seconded, there was no discussion, the vote was taken, the motion passed and it was so ordered.)

THE CHAIR: All right, we come now to the election of Officers. The floor is open for nomination for president elect.

DR. JOHN ARTHUR SIEGLING: Mr. President and members of the delegation of the South Carolina Medical Association, I wish to place in nomination for president of this organization the name of a personal friend who has the unanimous approval of our delegation and the Charleston County Medical Society. He is a long time friend of mine and I know some things about him that you don't, which I shan't divulge to you at this time, but you should know that he is a graduate of Princeton University, where he was Phi Beta Kappa; he received his medical degree at the Medical College of South Carolina where he

was elected to the honorary Medical Fraternity, AOA; he received his special medical training at that other cradle of culture and learning, Boston, at the Boston City Hospital; in preparation for his possible election to this high office he has served in many ways by election to high offices in organized medicine. On the local level he has served as secretary and president of the Medical Society of South Carolina and Chairman of the building program of Roper Hospital. On the State level he has served this Association as secretary for the past nine years where, as a member of Council, he has learned the policies and machinery of action in this Association. On the national level he has served as Governor of the American College of Physicians and is presently Chairman of its National Finance Committee. The scion of a noble family of South Carolina, following in the footsteps of his revered father, it is my feeling that this man through his native intellect, his experience in holding elective offices in this Association, and in the diligence with which he has executed the responsible positions which he has held, deserves to be included in that honorable group of revered physicians of South Carolina, the past presidents of this association who have served us for the last 114 years. It gives me great pleasure and I consider it a privilege to be allowed to nominate Robert Wilson of Charleston for presidency of this association. (Applause)

THE CHAIR: Gentlemen, you have heard the nomination, do I hear a second? (It was seconded by many throughout the House) Any other nominations? DR. CLAY EVATT, of Charleston, (Recognized), Mr. President, I move the nominations be closed and Dr. Wilson be elected unanimously.

THE CHAIR: You have heard the motion, gentlemen, seconded by Dr. Cone. Those in favor please say "aye," (the motion was carried and Dr. John Brewer was asked to bring Dr. Wilson in) (Applause)

(Vice President) THE CHAIR: Do I hear nominations for Vice-president?

DR. HARRY C. TILLER (Recognized) Mr. President, I nominate Dr. Samuel Lee Miller of Georgetown. (This was seconded by Dr. Norman, and by Dr. Watson.) Any further nominations?

DR. RALPH BAKER, of Newberry (Recognized) Mr. President, I would like to nominate Dr. Robert E. Livingston of Newberry, for Vice-President. (There were several seconds from the floor.) Are there any further nominations?

DR. NORMAN EADDY (Recognized) I move the nominations be closed, Mr. President. (This was seconded, the vote taken and carried.)

THE CHAIR: Prepare your ballots, I will ask the tellers to prepare the ballots for vice-president for Dr. Livingston and Dr. Samuel Miller.

(Dr. Robert Wilson comes into the room)

Gentlemen, your President-Elect. (All the convention rises as Dr. Wilson is escorted to the rostrum.)

DR. ROBERT WILSON: Gentlemen, I have been a member of the House of Delegates continuously for the last twenty-five years and I appreciate very much your designation of me as president-elect. Thank you all. (Applause)

(Secretary) THE CHAIR: While we are waiting on the report of the tellers I will now entertain nominations for secretary.

DR. WESTON (Recognized) I have the name of a man who I think can fill the shoes of this large individual who has just retired from office after nine years. This man was born in Hickory Grove, S. C., which is York County, if you don't know where it is, and he is the son of a doctor, whose mother and father are now deceased, he has two sisters and he is pretty well—they are living in the midlands of South Carolina, he is married, has three children. His education is well worth while mentioning, he graduated at Duke, he was there as a resident in internal medicine, he taught one year at the University of Alabama, since which time he has been practicing his profession as an internist in Columbia. He has been the president of the Duke Alumni and the general Alumni Association. He is now on the Board of Trustees at that institution; he has been a past president of the Columbia Medical Society, he has served on innumerable reference committees of this organization at our state meetings. He is the man who is vitally interested not only in his profession but he has kept up with the profession and you can absolutely depend on what he says and what he does. Now, he is interested in allergy, therefore he knows to what you are sensitive. It gives me great pleasure to introduce and to nominate a man of real quality, Dr. Ben N. Miller, as secretary of this organization. (Applause)

(This nomination was seconded by many; motion was made by Dr. Milling that the nominations be closed, this was seconded and passed)

THE CHAIR: Dr. Ben Miller, you are it. (Applause)

(Results of the vote for vice-president) In the vote between Dr. Samuel Lee Miller and Dr. Robert E. Livingston for Vice-President, Dr. Miller has won. Is Dr. Miller in the house? If not, I will ask Dr. John Brewer, Chairman of Council for Council's nomination for Treasurer.

(Treasurer) DR. JOHN BREWER: Mr. President, gentlemen, Council recommends that our present Treasurer succeed himself.

(This was seconded from the floor)

Question from the Floor: Who is it?

THE CHAIR: Dr. Howard Stokes. (Laughter)

DR. BREWER: You know its a funny thing—we were down here this morning and the ladies came in to present their problem, as usually women are a little deficient in their finances, and so after a little bit of argument I said "Now, boys, you know we are going to have to dig in our pocket and give these ladies this money, you'd just as well get it out." Howard Stokes had the sickest look on his face you have ever seen. And Mr. Meadors got up and finally saved the day by saying we still had around a little over $400.00 that we could turn in and it wouldn't unbalance the budget, so Howard then began to smile and feel better. So we do recommend that Dr. Stokes succeed himself, as treasurer.

(This was seconded by Dr. Milling and many; motion was made that the nominations be closed, which was seconded, the vote was taken and passed.)

THE CHAIR: Dr. Stokes, you are still our treasurer. (Applause) You will still write the checks.

(Delegate to A.M.A., 2 year term, the term of Dr. George Dean Johnson expires December 31, 1962.)

THE CHAIR: Do I hear a nomination for Delegate to A.M.A.?

DR. KING: Mr. President and members of the house, I wish to nominate a man whose ability has been proven by past performance, I would like to nominate George Dean Johnson to succeed himself. (This motion was seconded by many, there were no further nominations, motion was made that the nominations be closed, this was voted on and passed, and Dr. Johnson was elected to succeed himself as delegate to the A.M.A.)

(Alternate, term of Charles N. Wyatt expires Dec. 21, 1962)

THE CHAIR: I don't want the damn job, nominations are open for an alternate delegate to the A.M.A.

DR. POOLE (Recognized) Mr. President, I nominate Dr. Charles N. Wyatt to succeed himself.

THE CHAIR: I don't want it.

(Motion was made from the floor that the nominations be closed, this was seconded, and voted on with The Chair alone casting a negative vote.)

(Dr. Wyatt elected as alternate to A.M.A.)
(Councilors: 3-year terms)
THE CHAIR: The term of Dr. C. J. Scurry expires, the Third District, do I hear a nomination.
DR. McLANE: I would like to nominate Dr. C. J. Scurry to succeed himself. (This was seconded by many, motion was made that the nominations be closed, this was seconded, voted on and passed and it was so ordered that Dr. C. J. Scurry succeeds himself as councilor from the third district.

Sixth District—
THE CHAIR: The term of Dr. William L. Perry expires. Do I hear a nomination for councilor of the Sixth District?

DR. STOKES: Mr. President, I nominate Dr. William L. Perry to succeed himself. (This was seconded by many; motion was made by Dr. Eaddy that the nominations be closed, this was seconded, voted on and passed and Dr. William Perry was elected to succeed himself.)

Ninth District—
THE CHAIR: The term of Dr. John M. Fleming expires, do I hear a nomination for councilor of the Ninth District?

DR. L. SMITH: I nominate Dr. Fleming to succeed himself, Mr. President. (This was seconded by many; motion was made that the nominations be closed, this was seconded and passed and Dr. John M. Fleming was elected to succeed himself.

Members of the Mediation Committee—
THE CHAIR: Two are nominated from each district, these names will be put on the board, in just a few minutes.
In the meantime I would like to skip to the Benevolence Fund Committee Member, a 3-year term. The term of Dr. O. B. Mayer expires, do I hear a nomination for that committee?
DR. BURNSIDE: Mr. President, I move that Dr. Mayer be re-elected to succeed himself.
DR. MAYER: Mr. President, it has been my pleasure and privilege to serve on this committee three years. It is a relatively new committee and I feel that the sponsors of this committee ought to be spread around in order that the Association may know more about it. I, therefore, ask that my name be withdrawn.
THE CHAIR: Is that agreeable, Dr. Burnside?
DR. BURNSIDE: Yes, sir.
THE CHAIR: All right, nominations for the Benevolence Fund Committee to replace Dr. O. B. Mayer are in order, do I hear a nomination?
DR. EADDY (Recognized) Mr. President, I nominate Dr. Charles J. Lemmon, Jr., of Columbia. (This was seconded by many, there were no further nominations, motion made that nominations be closed, this was seconded and passed, and it was so ordered.)
(Members of the State Board of Medical Examiners, 4-year terms)
THE CHAIR: The term of Dr. George R. Wilkinson, of the fourth District expires, do I hear a nomination for the 4th District?
DR. BREWER (Recognized) I nominate Dr. George R. Wilkinson to succeed himself. (This motion was seconded by Dr. Lesesne Smith; motion was made that the nominations be closed, this was seconded and passed and it was so ordered.)
THE CHAIR: For the state at large, the term of the late W. R. Tuten expires, do I hear a nomination?
DR. THOMAS: Mr. President I put in nomination the name of Dr. W. O. (Bill) Whetsell of Orangeburg. Most of us know him, he is the recent past president of the Alumni Association, in general practice in Orangeburg and very active in medical circles. (This was seconded by Dr. Wells) Are there any further nominations?
DR. GEO. R. WILKINSON (Recognized) I propose the name of Dr. Harrison Peeples. (This was seconded by Dr. Lynch, there were no further nominations; motion was made that the nominations be closed, this was seconded, voted on and passed.)
THE CHAIR: You will prepare your ballots between Dr. Whetsell of Orangeburg and Dr. Peeples of Estill.

THE CHAIR: While that is going on, Gentlemen, will you be thinking about some member for the Hospital Advisory Council of the State Board of Health, the term of Dr. Pierre F. LaBorde, Jr., expires, a 4-year term. Do I hear a nomination for this?
(Motion was made that Dr. LaBorde succeed himself. This was seconded by Dr. Gressette. Motion was made, seconded and passed that nominations be closed.) Dr. Pierre F. LaBorde, Jr., succeeds himself on the Hospital Advisory Council of the State Board of Health.
(Member of State Board of Nursing Examiners—5-year term.)
THE CHAIR: The term of Dr. Wyman W. King expires on the State Board of Nursing Examiners, do I hear a nomination?
(Motion was made that Dr. King succeed himself; this nomination was seconded by Dr. Tucker Weston; motion made that the nominations be closed, this was seconded and passed; the vote was taken on the nomination of Dr. King and it was passed and so ordered.)
THE CHAIR: Going on the blackboard now are nominees for the Mediation Committee from the 3rd, 6th and 9th districts. Two nominees will be made by the councilor of these respective districts. You vote for one each of the districts, please.
Third District—Dr. Robert Clark, Jr., Abbeville; Dr. Dossey H. McFadden, Newberry
Sixth District—Dr. Harry Allen, Jr., Florence; Dr. Samuel O. Cantey, Marion
Ninth District—Dr. Charles B. Hanna, Spartanburg; Dr. Francis P. Owings, Union.
(Announcement of tellers—State Board of Medical Examiners)
THE CHAIR: Dr. W. O. Whetsell has been elected to the State Board of Medical Examiners.
THE CHAIR: While that vote is being tallied—the final thing on the agenda this morning is the selection of place for the 1963 Annual Meeting. We have had invitations from the Chamber of Commerce and Mayor of the City of Greenville, we have a letter here from the Ocean Forest Hotel extending an invitation to meet here next year. Are there any other invitations to be extended.
Dr. William S. Chapman of Myrtle Beach (Recognized) We would like to invite you back to Myrtle Beach next year.
THE CHAIR: Dr. Chapman of Myrtle Beach says they would like to have us back here next year. Do I hear any further invitations?
(When the vote was taken as to Greenville or Myrtle Beach, S. C., the convention was almost unanimous in its vote to return to Myrtle Beach.)
THE CHAIR: Gentlemen, Myrtle Beach it is. (Applause) (Announcements) Mediation Committee will meet immediately following adjournment in this room.
Those interested in AMPAC, as explained by Mr. Joe Miller, will meet immediately after adjournment of the House of Delegates on the orchestra rostrum.
(Result of voting on Mediation Committee)
THE CHAIR: Gentlemen, the following have been elected to the Mediation Committee, Dr. Clark from the 3rd Dist., Dr. Cantey, from the 6th Dist., and Dr. Owings, from the 9th District.
THE CHAIR: Gentlemen, unless I hear something further in the way of business this meeting of the House of Delegates is declared adjourned sine die.

Book Reviews

GENERAL PATHOLOGY. Edited by Sir Howard Florey, 3rd Edition. W. B. Saunders Company, 1962. Philadelphia and London. pp. 1104. $22.00.

The publication of the third edition of a medical text within eight years indicates that it has received considerable acceptance in the medical community. The subject matter of "General Pathology" is derived from lectures delivered to "honor" medical students at Oxford University and is intended as a survey of basic pathologic concepts in pathology and bacteriology. As such, the title of this book is misleading to the American reader because a different connotation is ascribed to the term in this country. A better title might be "Basic Pathology" because a detailed and lucid discussion of the basic pathologic, bacteriologic and immunologic processes is presented. The subject matter is discussed from an experimental basis with extensive references to current investigative findings and the writers are frequently researchers of note in the fields discussed. The illustrations are excellent and electron microphotographs are utilized freely to illustrate many points.

This book provides little specific discussion of disease entities, but the contributions to this volume do provide a broad background in which to appreciate the pathologic changes produced by disease. This book is not recommended as a primary text for the study of pathology; however, it does provide information of great value to the advanced student and to the perceptive physician who desires additional information concerning the principles of disease. This book is especially valuable to the research worker in related fields and to the practicing pathologist because it provides such an excellent summary of recent work.

It is a pleasure to recommend this book as a reference text on the basic principles of pathology, bacteriology and immunology. As such it will provide an excellent supplement for the advanced student, the researcher and the pathologist.

E. A. Dreskin, M.D.

HEMODYNAMICS OF AORTIC AND MITRAL VALVE DISEASE. Alvin J. Gordon, M.D., Paul A. Kirschner, M.D., and Howard L. Moschovitz, M.D. 136 pages. New York, Grune & Stratton, Inc. $5.75.

The book is a compilation of the authors' experiences with transbronchial left heart catheterization, with some additional data from direct left ventricular needle puncture and from right heart catheterization. It is an excellent report of measurements in patients being investigated for suitability for surgery in left-sided heart lesions. As such, it will be of interest mainly to cardiologists and cardiac surgeons.

John A. Boone, M.D.

PRACTICAL ANESTHESIOLOGY, by Joseph F. Artusio, Jr., M. D. and Valentino D. B. Mazzio, M. D. 1st Edition. The C. V. Mosby Co. St. Louis. 1962. $7.75.

This book is written, by intention and content, for part-time physician anesthetists, residents in anesthesiology, nurse anesthetists and students. The book is well written and well illustrated. Little that is very new or controversial is presented.

I believe that more attention could have been paid to the pharmacology of the anesthetic agents. The chapters dealing with techniques of administration are rather scanty in detail. Fluothane is barely mentioned at all and peripheral nerve blocks are not discussed.

The chapters on shock, blood transfusions, before and after anesthetic care, medical evaluation and balanced anesthesia will be especially helpful to the nurse and part-time anesthetist.

Jack M. Vander Wood, M. D.

ILLUSTRATED MANUAL OF NEUROLOGIC DIAGNOSIS. R. Douglas Collins, M. D. J. B. Lippincott Co., Philadelphia. $12.00.

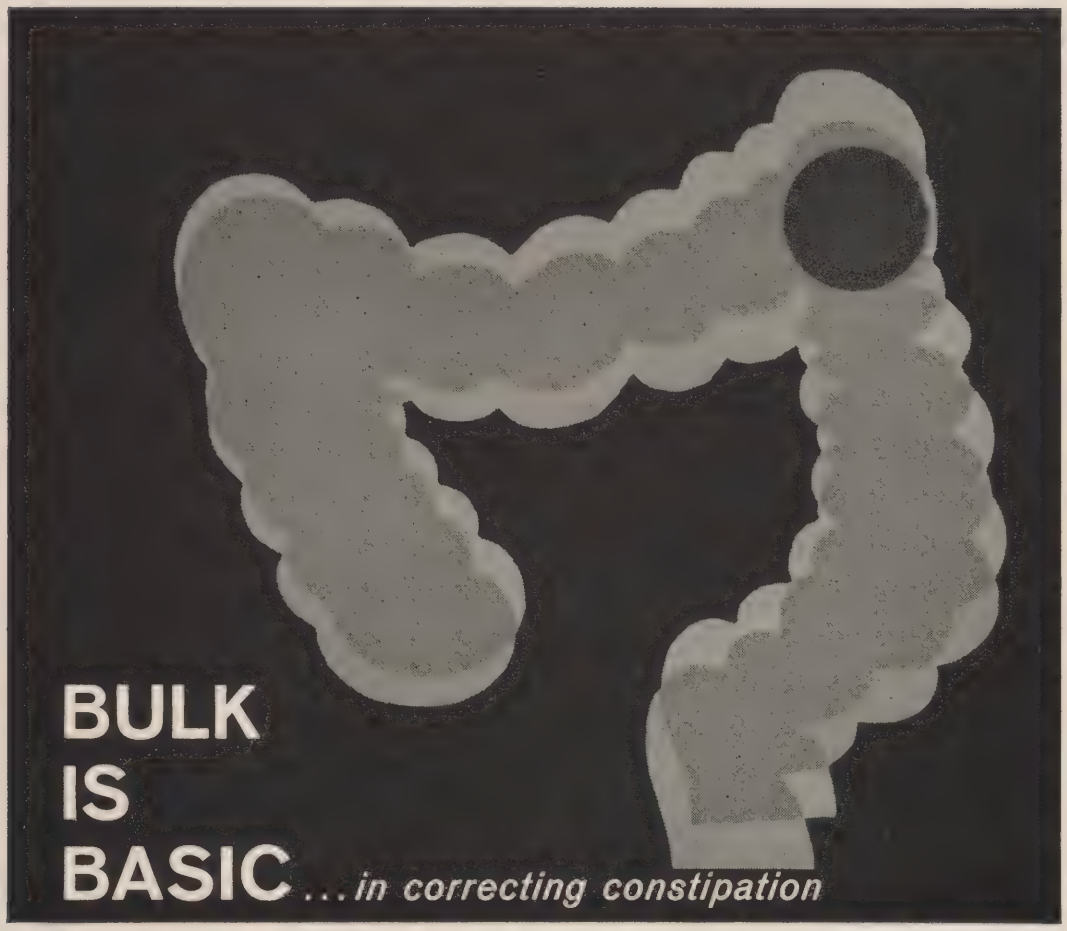
As the scope of medical education continues to expand, and as students and practitioners alike circumvent the field of neurologic disease because of insufficient formal education and clinical experience, this volume represents a unique, simple, practical and systematic approach to diagnosis of the common neurologic illnesses. It requires only a foundation in neuroanatomy and basic physical diagnosis. If one performs the neurologic examination as pictorially displayed and analyzes the abnormal findings according to the several diagnostic tables, there should be little difficulty in arriving at the correct diagnosis.

J. D. Morgan, M. D.

THE NATURE OF PSYCHOTHERAPY. A Critique of the Psychotherapeutic Transaction, by Walter Bromberg, B.S., M.D. Grune & Stratton, Inc. New York 1962. $4.50.

This book is the compilation of papers which the author has presented to various psychiatry organizations during the past several years. The writer tries "in this book to distill a universal out of the myriad worlds of psychotherapeutic method." For his thesis he has proceeded on the basis of "a logical analysis."

"Verbal description in psychiatry attempts to pack the drama of life into bundles of desiccated words, words which tightly constrict the drama of life they enclose. To a degree, after the word-symbol has interpreted, teased out, so to speak, and explicated,



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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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Research in the Service of Medicine

something which approaches the life situation under description emerges. But it is empty of the flavor and iridescence that minute-to-minute changing relations between two human beings exhibit," is an example of some of Dr. Bromberg's dissertation.

There is complexity throughout the papers with tendencies toward poetical personal philosophising; however, serious students and practitioners of psychotherapy will be able to extricate some cognition of the nature of psychotherapy.

Ramsey Mellette

CARCINOMA OF THE CERVIX. By John B. Graham, M. D., Luciano S. J. Sotto, M. D., and Frank P. Paloucek, M. D. W. B. Saunders Company, Philadelphia and London, 1962. $14.00.

This book is both well written and well arranged. A tremendous amount of information is presented in an easily digestible manner. The clear, concise style gives the essence of the subject with proper amplification. The section on statistics is adequate for the statistically minded reader without being burdensome for others. Classification, staging, calculation of radiation dosage and description of methods, discussion of surgical techniques and complications are among the many subjects treated. Actual case histories are used to illustrate certain points.

This book is recommended especially for medical students and house staff.

J. R. Sosnowski, M. D.

REHABILITATION OF A CHILD'S EYES, 3rd Edition. Herbert M. Katzin, M. D., and Geraldine Wilson, R. N. C. V. Mosby and Co. St. Louis. $3.75.

This book is an old standby for pediatricians, ophthalmologists, and parents of children with strabismus. Its lucidness, good diagrams and adequate discussion of strabismus have done much to allay the fears of apprehensive parents.

The book explains how the eyes work as a team, what happens when they cross, and a general description of treatment.

Some of the more modern treatments are discussed such as pleoptics (for suppression blindness), newer orthoptics, miotics, and many other diagnostic and training aids.

It is a book that all ophthalmologists and pediatricians should read and a definite "must" for parents of a child with strabismus.

W. W. Vallotton, M. D.

RENAL BIOPSY, CLINICAL AND PATHOLOGICAL SIGNIFICANCE. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and M. D. Cameron. Little, Brown & Co. Boston, 1962. 395 pages. Price $10.50.

This book is a compilation of the papers and discussion presented at a March 1961 symposium on all aspects of renal biopsy. Such authorities as Vernier, Hamburger, Rich, Earle, Heptinstall, Kark, and Brun, as well as many others are contributors. Topics given extensive coverage include newer knowledge of the ultrastructure of the glomerulus in the normal state as well as in disease gained by electron microscopy. The nephrotic syndrome is stressed in this section. The findings of Earle and Jennings in post-streptococcal glomerulonephritis are described. The knowledge gleaned from biopsy of the kidney in lupus erythematosus is also reviewed. Some of the problems of interpreting biopsy material from patients with pyelonephritis are discussed. Appropriate references are listed after each presentation. The book will be of value and can be recommended to those whose interest in the natural history and histology of renal disease demands a good summation of current knowledge of some of the aspects of renal biopsy at the literature level. The presentations presuppose considerable familiarity with the material discussed.

Cheves McC. Smythe, M. D.

PREVENTIVE MEDICINE IN WORLD WAR II: Volume V. COMMUNICABLE DISEASES TRANSMITTED THROUGH CONTACT OR BY UNKNOWN MEANS, Colonel John Boyd Coates, Jr., M. C., Editor in Chief. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 1960. Pp. 530. Price $5.75.

This interesting book represents an additional part of the official history of the U. S. Army Medical Department. This volume (V) should be of particular value to physicians in the fields of preventive medicine, infectious diseases, and military medicine. The Army's experience during World War II with such widely divergent diseases as leprosy, schistosomiasis, poliomyelitis, infectious mononucleosis, hookworm, etc., is outlined in detail. The section on viral hepatitis is presented unusually well, and makes very interesting reading. The serum hepatitis epidemic of 1942 is discussed and provides useful information for future epidemiologic investigations, as well as good medical history. A large section of the book is devoted to the Army's experiences in the prevention and control of venereal diseases in various locations throughout the world.

It would seem that the primar use for this history will be that of reference book; however, as a history, it is both interesting and informative for the general medical reader.

W. Wesley Seymour, M. D.

TEXTBOOK OF OBSTETRICS. By Duncan E. Reid, 1087 Pages, Philadelphia, 1962, W. B. Saunders & Company. Philadelphia. $18.50.

This is a thorough, easily read and well illustrated textbook of obstetrics. One of the author's main objectives is to relate the process of human reproduction to the general framework of medicine and biology. Emphasis has been placed on medical and surgical diseases of pregnancy, maternal and fetal physiology, and genetics, with less attention focused on the mechanics of birth.

A successful attempt has been made to write a book catered both to students as a text and physicians as a reference. Controversies are discussed, although Dr. Reid admits his suggestions lean towards those believed at his institution. Abundant illustrations help simplify and emphasize points; however, statistics are held to a minimum. The bibliographies appear adequate even though at the end of the book there is a list of suggested readings pertaining to reproductive biology.

The chapters on fetal growth and physiology, normal and abnormal obstetrical pelvis, medical and surgical diseases of pregnancy, and genetics deserves special attention due to their completeness.

In summary this is an excellent textbook of obstetrics. Thoroughness is emphasized, controversies are discussed, illustrations are abundant, and managements are suggested. I recommend this textbook of obstetrics to both those desiring complete coverage of the field as well as those seeking a reference book.

Lawrence L. Hester, Jr., M. D.

MEDICAL PHYSIOLOGY. Edited by Philip Bard. The C. V. Mosby Co. St. Louis, Mo. 1961. 1339 pp. 508 illus. $16.50.

This enduring text, once known as MacLeod's "Physiology and Biochemistry in Modern Medicine" has now gone through its eleventh edition, the fourth under the editorship of Dr. Bard. The last edition appeared five years ago, and much modernization is evident in this new one, especially in the sections on Circulation and Renal Function. Some portions are not much changed, but the book represents the best of current knowledge of physiology. Unavoidable circumstances prevented a reworking of the section on Special Senses.

This book on physiology maintains a position in the forefront in the race for the completely satisfactory textbook. The medical graduate and the investigator in physiology who use this text will find not only the experimental bases for the facts and concepts of physiology but also a well balanced portrayal of the limitations and the present or very recent status of these concepts, and further, the excellent documentation will enable him to trace them from the recent literature back to their origins in basic works. Consequently with this text as a guide, there is almost no aspect of physiology which cannot be successfully explored. To say this of a textbook in a field as vast and intricate as physiology has become, is to accord it high praise indeed.

Theodore Bernthal, M. D.



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Professor Emeritus
The Johns Hopkins Hospital
and
Members of the Faculty of
Emory University School of Medicine
69 Butler Street, S. E.
Atlanta 3, Georgia

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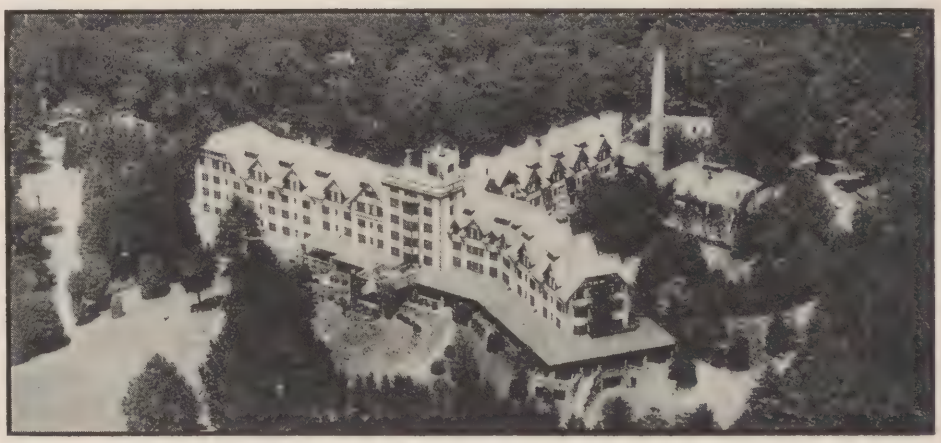
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Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-Ray.

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Logical support for the atherosclerosis diet

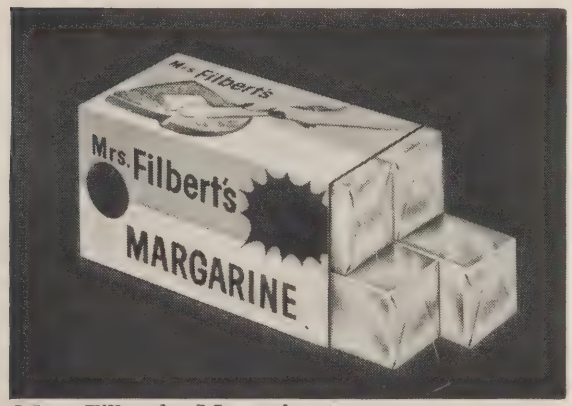
A recent report* in the *JAMA* on atherosclerosis states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, it is in your professional interest to know about the fatty acid composition of the margarines from Mrs. Filbert's.

Each of Mrs. Filbert's Margarines is over 80% unsaturated and offers unique properties useful in the control of serum lipids by dietary means.

Moreover, when you recommend any one of Mrs. Filbert's Margarines, your patient is assured of unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).



Mrs. Filbert's Margarine is a popular, conventional-type margarine with no premium price. It is made from the finest domestic vegetable oils, which are partially hydrogenated for texture, but remain over 80% unsaturated. It has a ratio of polyunsaturates to saturates in excess of 1 to 1.



Mrs. Filbert's Whipped Margarine contains the same number of calories per pound as ordinary margarine, but contains 30% *fewer calories per pat* because it is whipped. When spread normally, it provides satisfaction with a reduction in fat calories. And its ratio of polyunsaturates to saturates exceeds 1 to 1.

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the welcome howl: loud and lusty

*"Demerol mg. 100 and scopolamine gr. 1/150 are given intramuscularly when the labor is established. Subsequently Demerol mg. 100 is given every four hours and scopolamine gr. 1/200 every three hours. Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished. In addition, there seems to be a relaxing effect on the cervix. . . . Accumulating evidence seems to indicate that this combination offers the best means of securing analgesia and amnesia in labor with the least risk to the mother and child."**

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* Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Co., 1958, p. 1029.

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Before administering, consult Winthrop's literature for additional information about dosage, side effects and contraindications.

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Appetizing diet food gives a patient an incentive.

How to help your patient stick to a low calorie diet

The secret ingredient in a successful diet is acceptance. A low calorie diet that lets the patient work out equivalent variations will win his approval. A too-rigid diet begs to be broken. Pictured are dishes any dieter would find appetizing: chicken flavored with garlic, fruit-garnished gelatin, grapefruit, raw carrot, celery, pepper and radish nibbles. Variations might be broiled fish, simple green salads. All can be interestingly seasoned, attractively served, to keep the patient's enthusiasm from flagging.

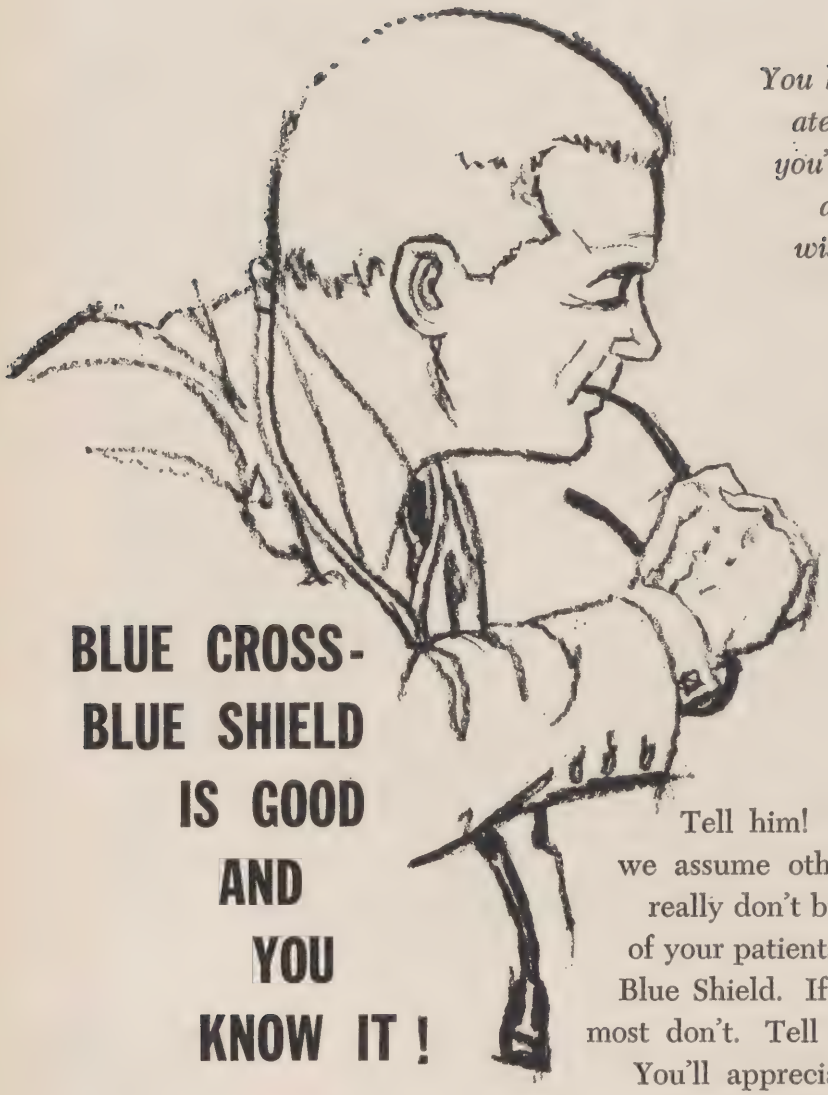


And a glass of beer can add zest to your patient's diet

104 calories, 8 oz. glass
(Average of American Beers)

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You know it because you created it. You know it because you're a doctor and have been able to rate it performance-wise with others.

Your patient may not know it though, and when he doesn't, he and you both come up short.

BLUE CROSS-BLUE SHIELD IS GOOD AND YOU KNOW IT!

Tell him! We often know things which we assume others know, when in fact they really don't but would love to. Fact is, most of your patients don't know about Blue Cross-Blue Shield. If they did, they'd carry it, and most don't. Tell 'em and they'll appreciate it. You'll appreciate it too the next time they use your services.

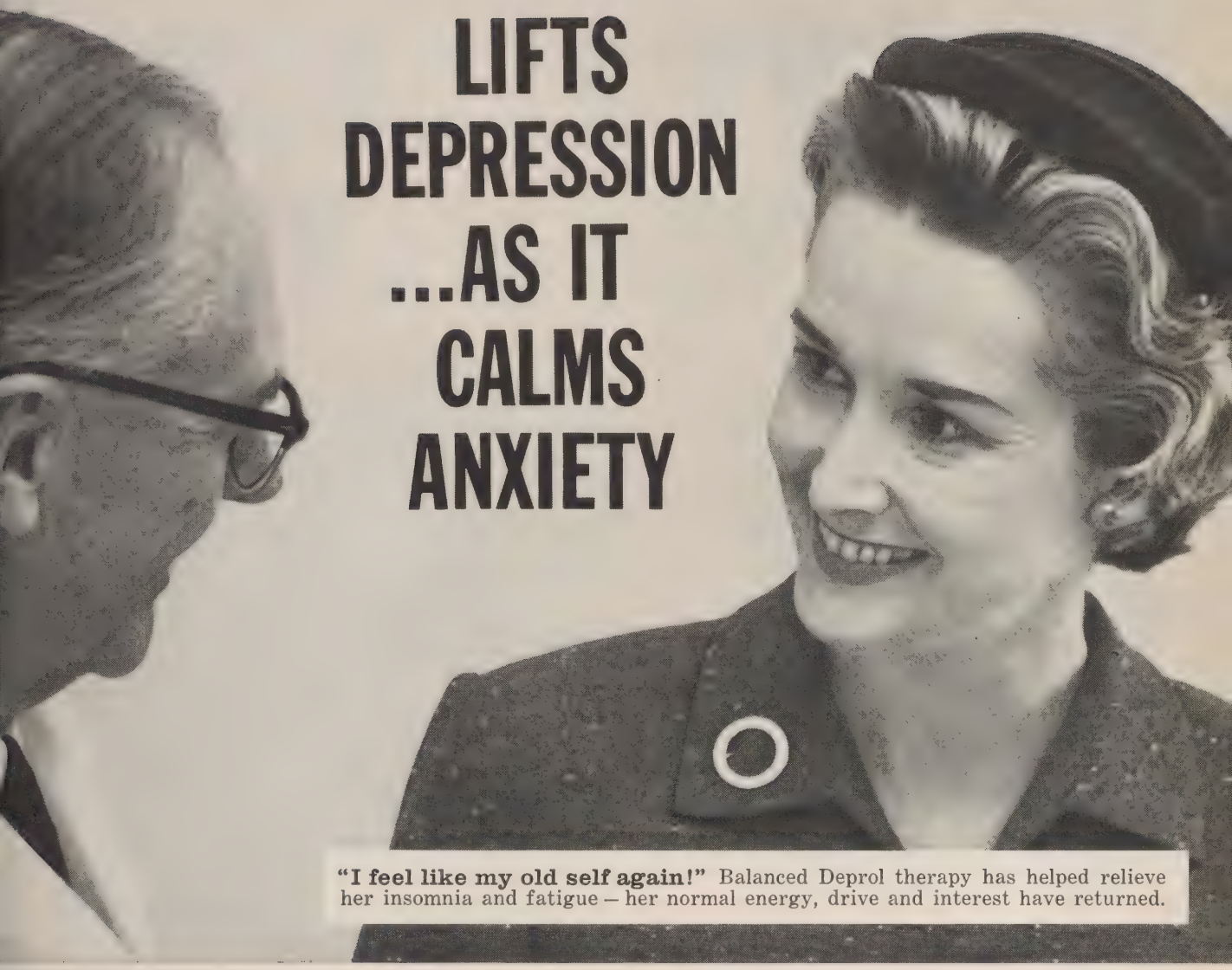
It's good and you know it. Now let your patients know it.

Preserve the free practice of Medicine — Promote Blue Shield

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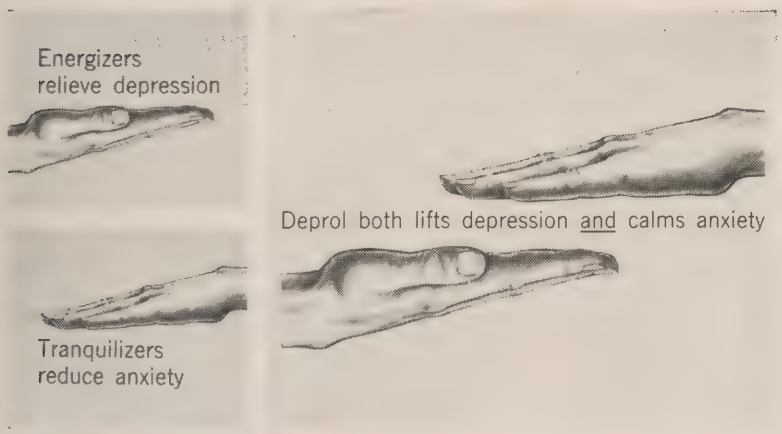
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"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

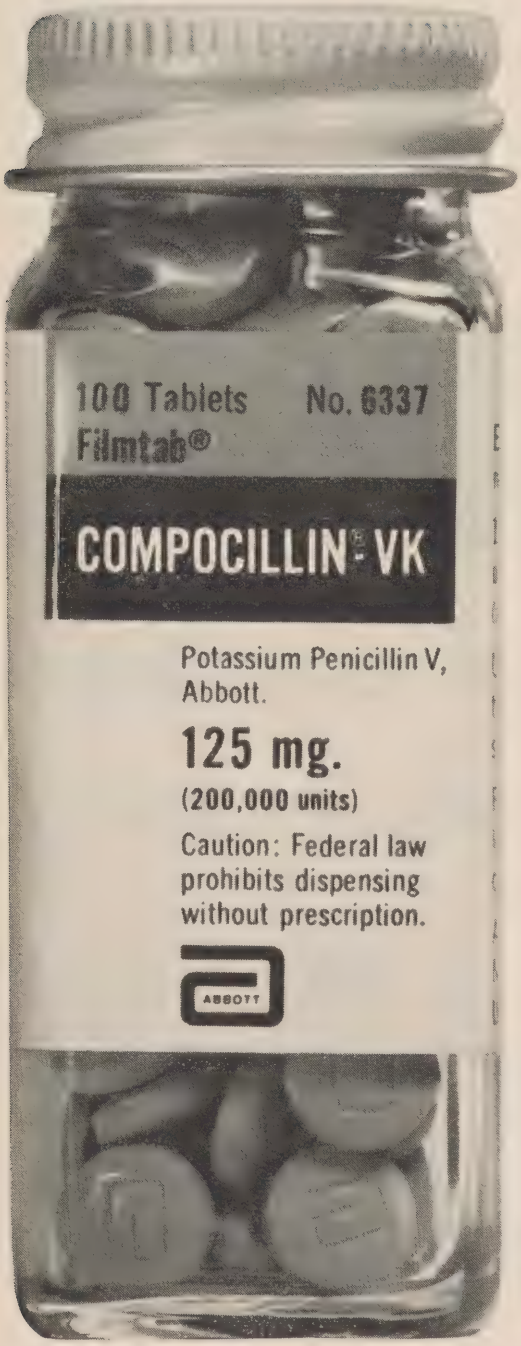
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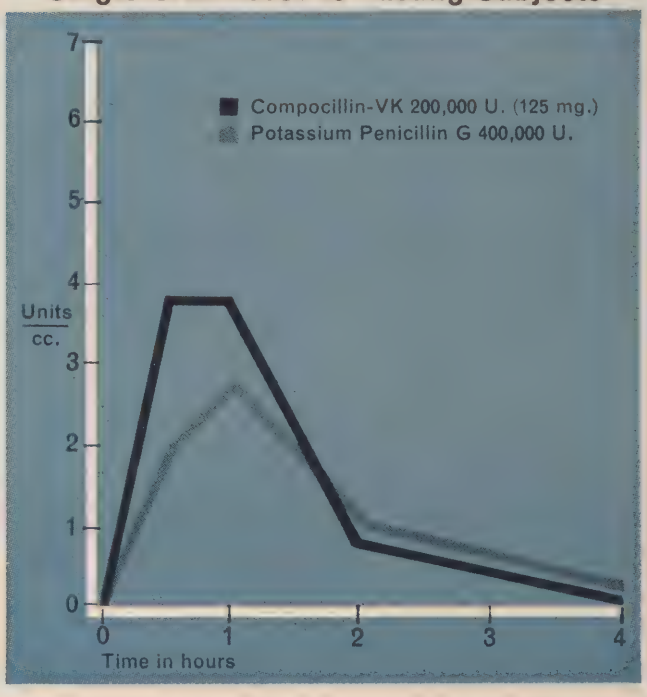
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Here's a penicillin that gives you...

PATIENT ECONOMY WHEN YOU WANT IT



Single Oral Doses to Fasting Subjects*



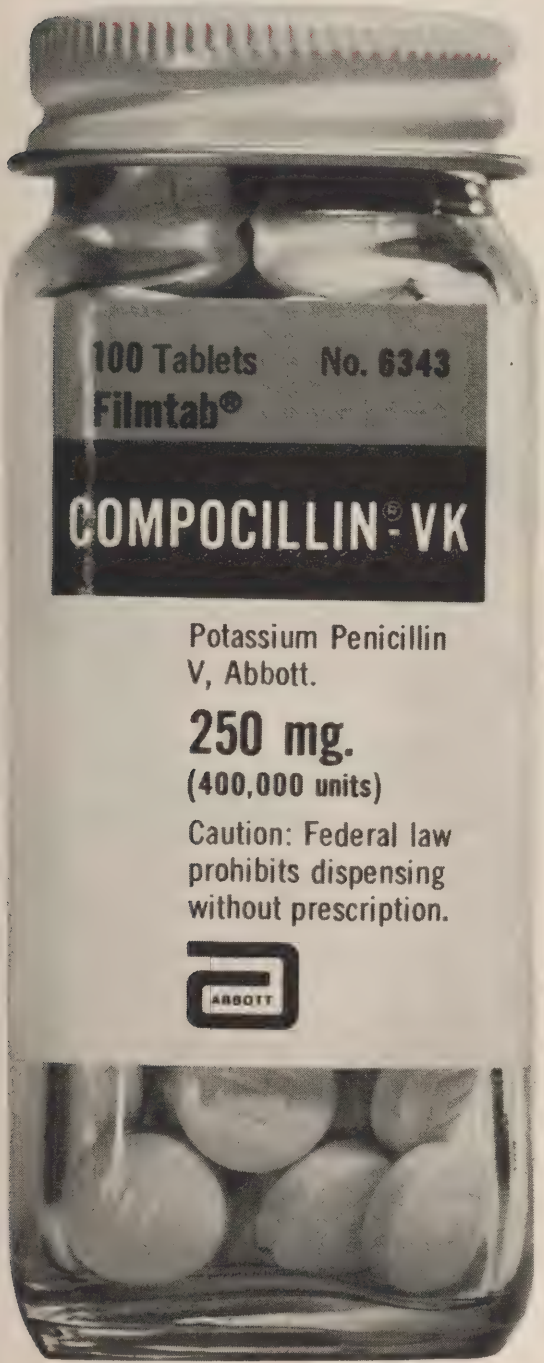
Consider milder bacterial infections

An example might be a respiratory infection. Here economy could be a definite factor in your thinking. In the chart above, you'll see that 200,000 units (125 mg.) of Compocillin VK produces blood levels at least equal to those obtained with 400,000 units of oral penicillin G potassium. This means that in less severe infections, Compocillin-VK may be given at *half* the dosage needed with oral penicillin G—with no sacrifice in blood levels. In these cases, the cost of Compocillin-VK therapy will be no more—and often will be less—than treatment with oral penicillin G.

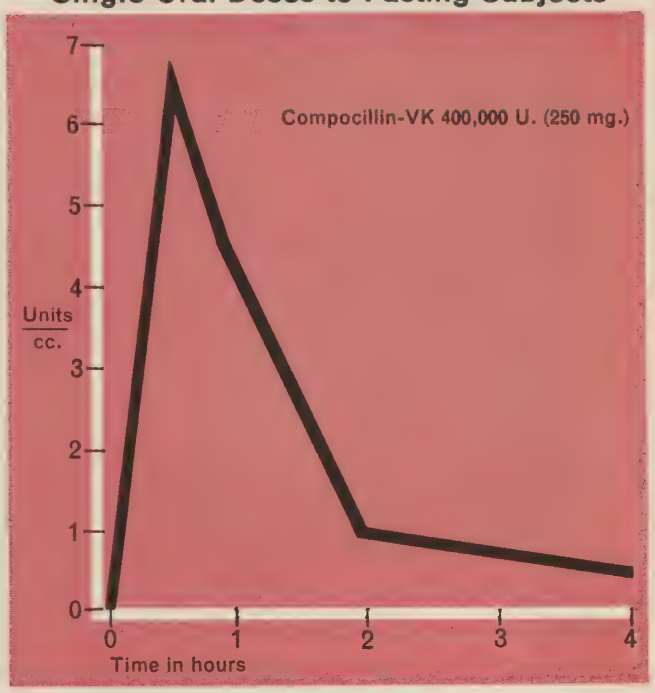
Compocillin-VK—the original potassium penicillin V • In Filmtab (125 and 250 mg.) and cherry-flavored Granules for Oral Suspension

Filmtab—Film-sealed tablets, Abbott: U.S. Pat. No. 2,881,085

PEAK EFFICIENCY WHEN YOU NEED IT



Single Oral Doses to Fasting Subjects*



Then, for severe infections...

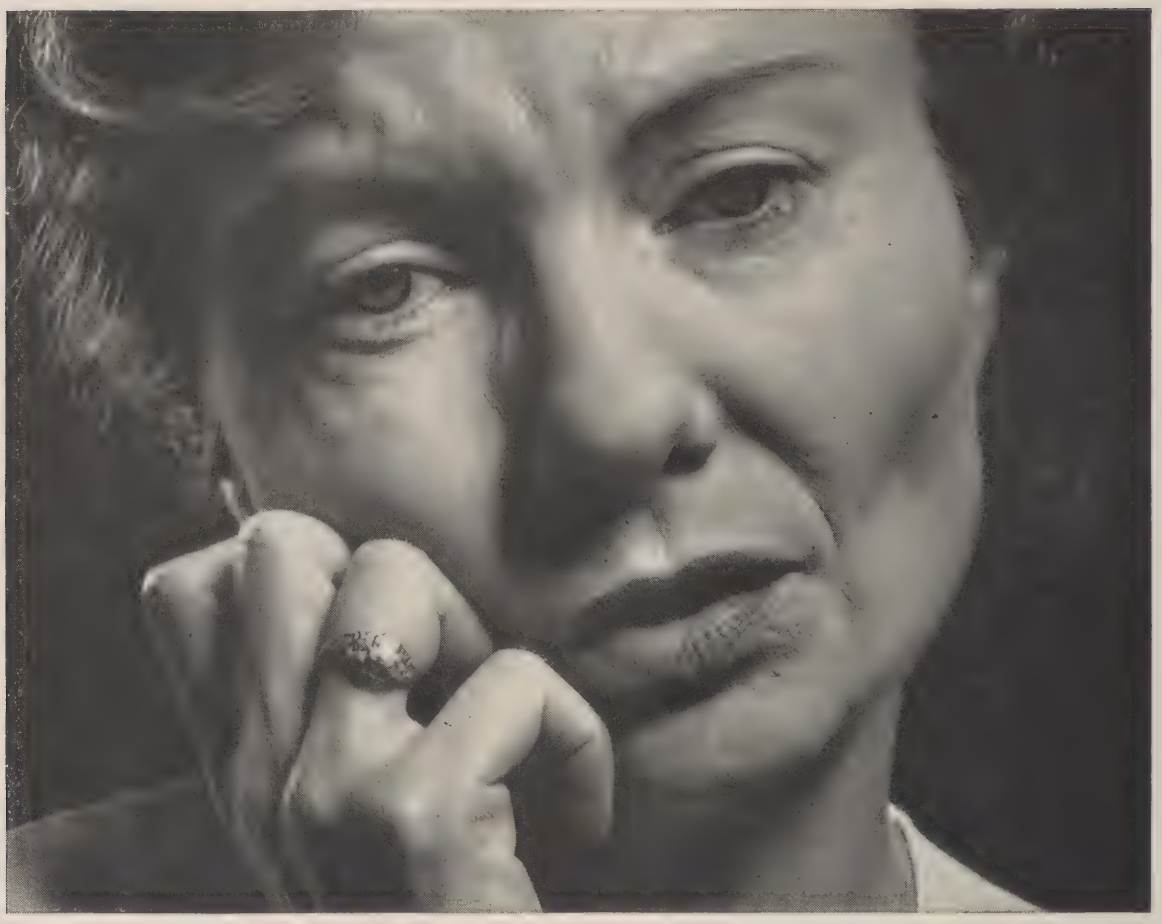
. . . where your primary concern is high peak serum concentrations, you can prescribe Compocillin-VK at *full therapeutic dosage* and get the maximum antibacterial activity possible with an oral penicillin. The chart above shows the rapid peak blood levels obtained with 400,000 units (250 mg.) of Compocillin-VK. Actually, these peaks occur faster—and are higher—than those obtained with intramuscular penicillin G. Indeed, Compocillin-VK has been used in cases previously reserved for parenteral treatment. The safety advantage (oral vs. injectable) goes without saying.

*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

ABBOTT LABORATORIES NORTH CHICAGO, ILLINOIS

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"just don't seem to care anymore"



NICOZOL® COMPLEX

helps you restore an "interest in life" to your middle-aged patients

NICOZOL COMPLEX provides a tonic stimulation of vital metabolic elements to restore strength and interest for your run-down, middle-aged patients. Its formula is designed to improve mental acuity . . . increase the use of oxygen by the brain . . . rebuild protein tissue . . . and increase appetite . . . check protein demineralization.

NICOZOL COMPLEX can help you keep your middle-aged patients active, alert and interested in themselves, their jobs and their surroundings.

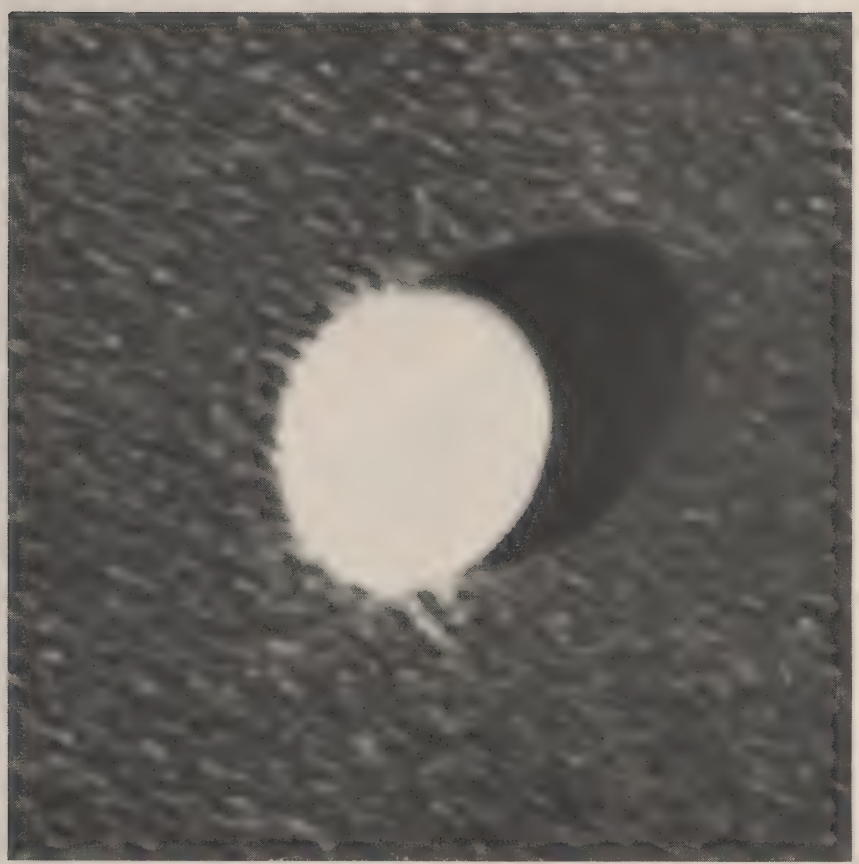
Supplied: NICOZOL COMPLEX (a pleasant-tasting elixir) in bottles of 1 pint, and 1 gallon.

Dosage: One teaspoon (5 cc.) three times daily, before meals. Instruct female patients to discontinue NICOZOL COMPLEX for 7 days after each 21-day course of therapy.

Each 15 cc. (3 teaspoons) contains:

Pentylenetetrazol	150 mg.
Nicotinic Acid	75 mg.
Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.01 mg.
Thiamine Hydrochloride	6 mg.
Riboflavin	3 mg.
Pyridoxine Hydrochloride	6 mg.
Vitamin B_{12}	2 mcg.
Folic Acid	0.33 mg.
Panthenol	5 mg.
Choline Bitartrate	20 mg.
Inositol	15 mg.
l-Lysine Monohydrochloride	100 mg.
Vitamin E (a-Tocopherol Acetate)	3 mg.
Iron (as Ferric Pyrophosphate)	15 mg.
Trace Minerals as: Magnesium 2 mg.; Manganese 1 mg.; Zinc 1 mg.	
Alcohol	15%

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Goliath *David*

Against the formidable and ubiquitous Staphylococcus aureus, PANALBA* gives you a powerful weapon. PANALBA is a selective combination of novobiocin (for its unique effectiveness against staph) and tetracycline (for its breadth of coverage). From the outset, your treatment has broader antibacterial coverage resulting from the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

That is why PANALBA offers excellent chances for therapeutic success.

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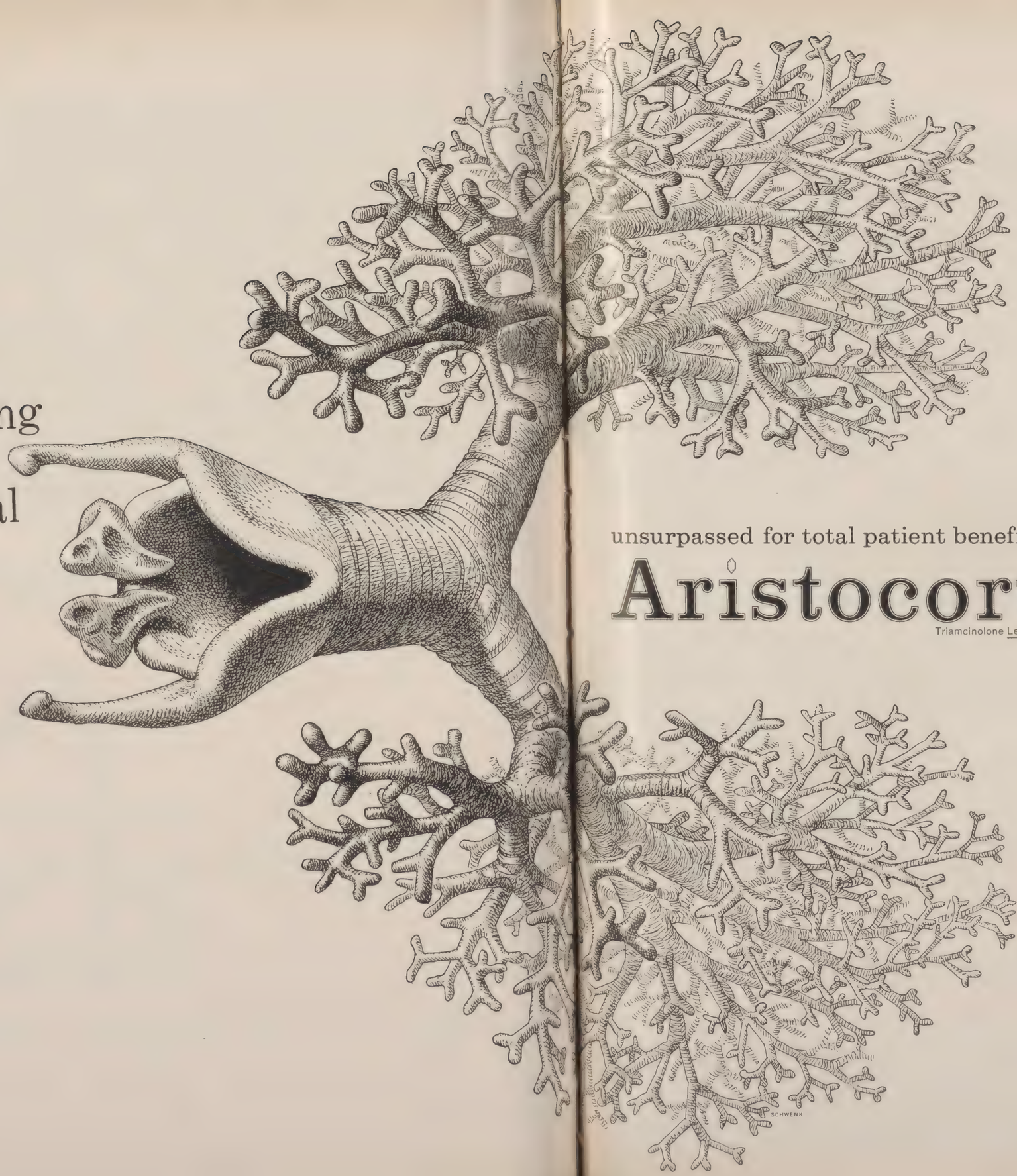
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gratifying
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in bronchial
asthma



unsurpassed for total patient benefits

Aristocort®

Triamcinolone Lederle

With ARISTOCORT, asthmatic patients obtain sustained relief of wheezing, dyspnea, and spasmodic coughing. It is of particular value in ameliorating severe attacks that may have serious sequelae. With ARISTOCORT, many patients who might otherwise be invalids are able to continue their customary livelihoods or maintain their regular household activities. Yet this symptomatic relief is not often accompanied by the hormonal collateral effects —sodium retention, edema, emotional disturbance, insomnia, voracious appetite— that so often have been a deterrent to steroid therapy.

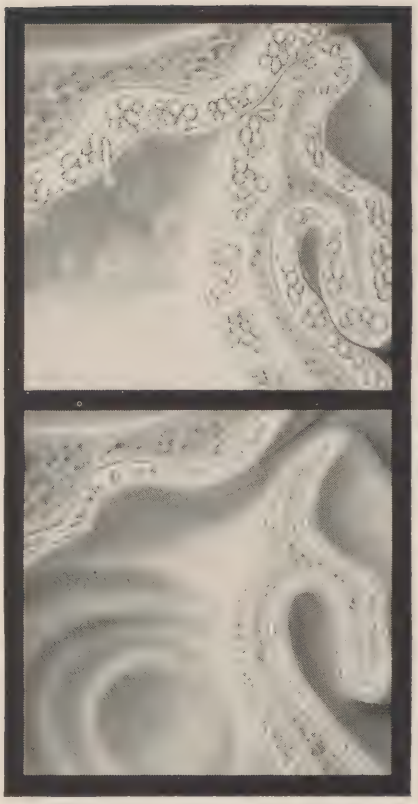
SUPPLIED: Scored tablets (three strengths), syrup and parenteral. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle

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In colds
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sinusitis

unsurpassed
in providing
drainage
space
without
chemical
harm



The clogged sinus
In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
Magnified anatomy of a portion of maxillary sinus showing mucous membrane with cilia and lymph glands. Ostium is normal and patent.

NEO-SYNEPHRINE®

brand of phenylephrine hydrochloride

hydrochloride

NASAL SPRAYS AND SOLUTIONS

When there is nasal turgescence, tiny orifices of sinus ostia tend to clog. Neo-Synephrine nasal solutions and sprays reduce edematous tissues on contact to provide prompt relief. As turbinates shrink, obstructed sinus ostia open, drainage and breathing become freer and the boggy feeling of a cold disappears.

Delicate respiratory tissue and its natural defenses are not harmed by exceptionally bland Neo-Synephrine; systemic effects are nil; it does not sting. For years it has been recommended for prevention and treatment of sinusitis.[1-3] Repeated applications do not lessen effectiveness.

Available in plastic nasal sprays for adults (½%) and children (¼%), in dropper bottles of ⅛, ¼ or 1 per cent.

1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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We invite you to take advantage of a professional discount

This is a saving of $39 per set over the regular retail price for innerspring mattress and matching foundation. Limit: one full or two twin size sets. MAIL TO: Sealy Mattress Co., 666 N. Lake Shore Dr., Chicago 11

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When you choose an anorectic—

"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



ESKATROL®
SPANSULE®

brand of sustained release capsules

PRESCRIBING INFORMATION

Formula: Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

Recommended Dosage: One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

Side Effects: Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

Smith Kline & French Laboratories



Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

More detailed professional information available on request.

Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

from boutonneuse fever in Africa to bronchopneumonia in South Carolina

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*

BRAND OF OXYTETRACYCLINE

Terramycin® capsules • syrup • pediatric drops
intramuscular solution • intravenous

also available with nystatin as TERRASTATIN® (capsules and oral suspension)

NEW **SPECIAL COUGH FORMULA**
for Children

Pediacof

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SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 cc.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
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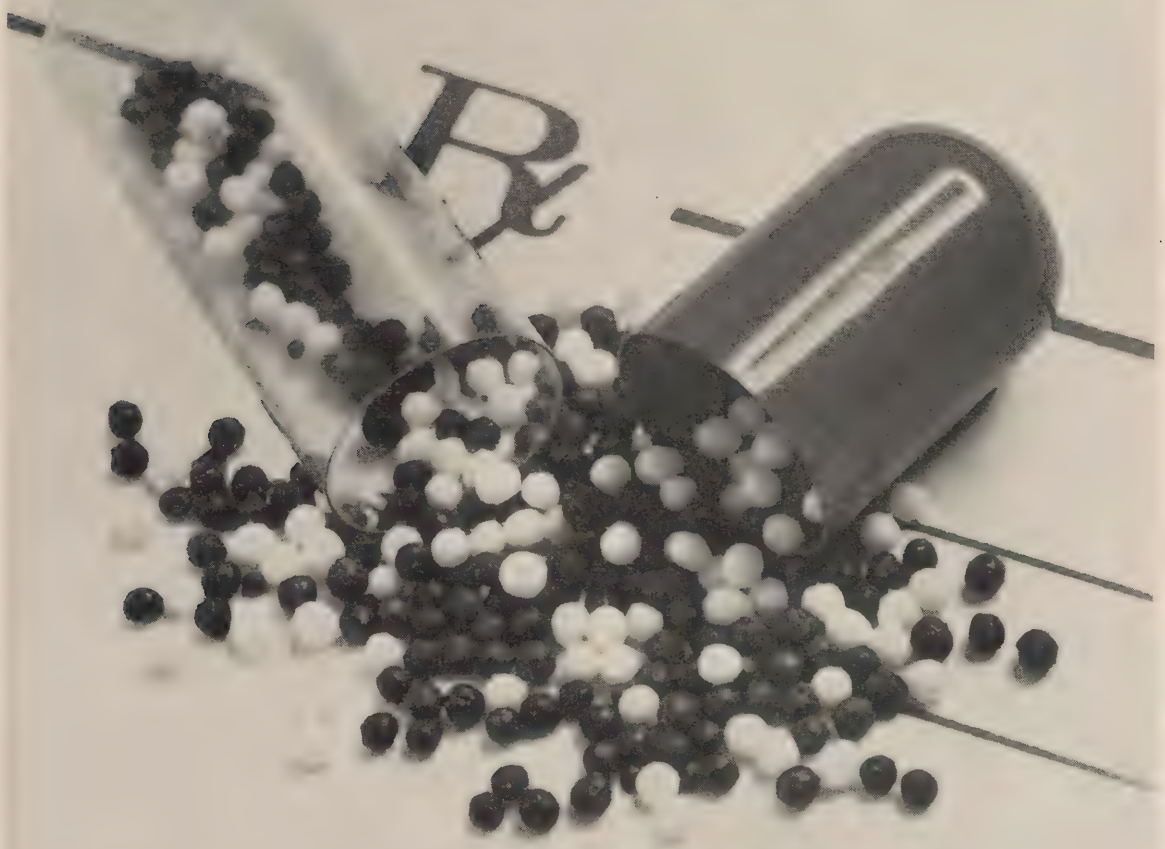
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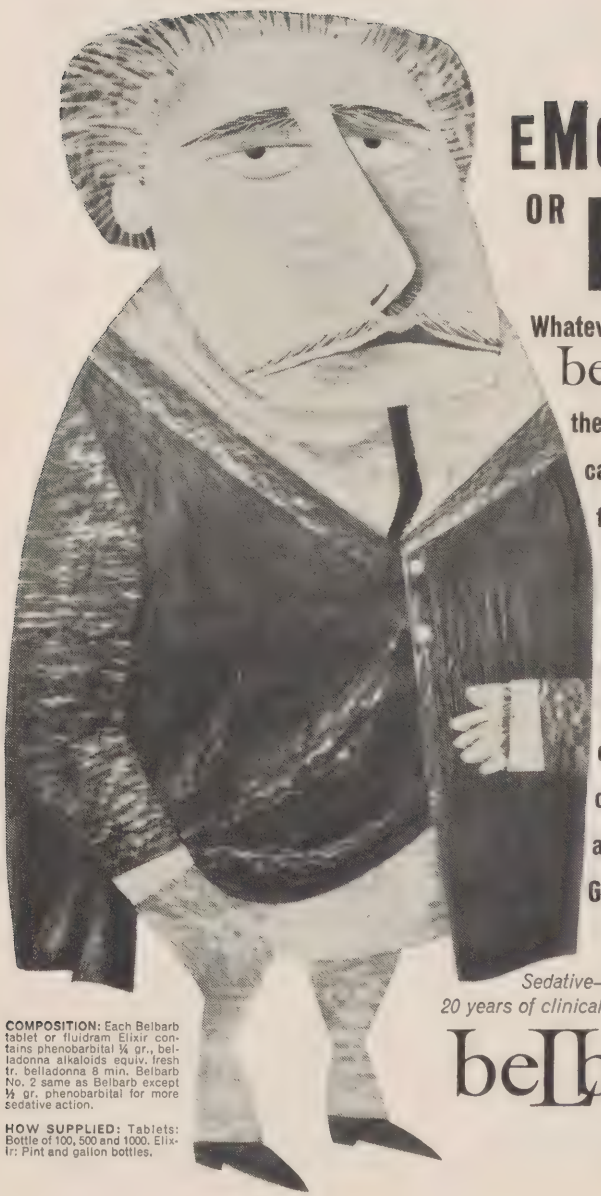
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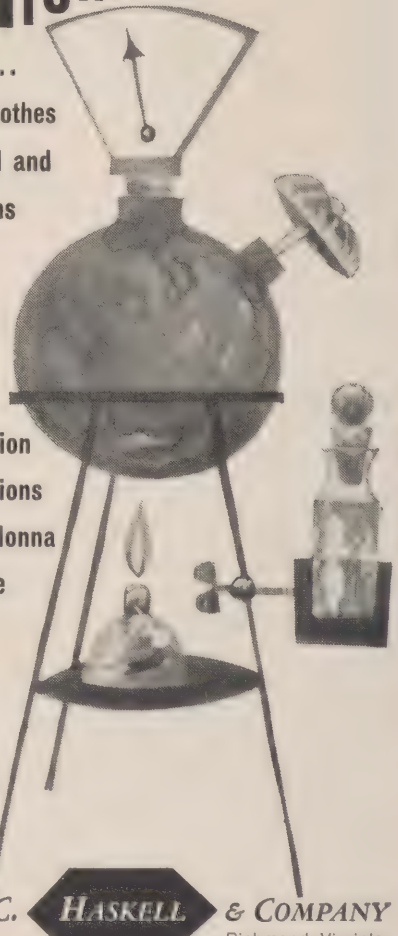
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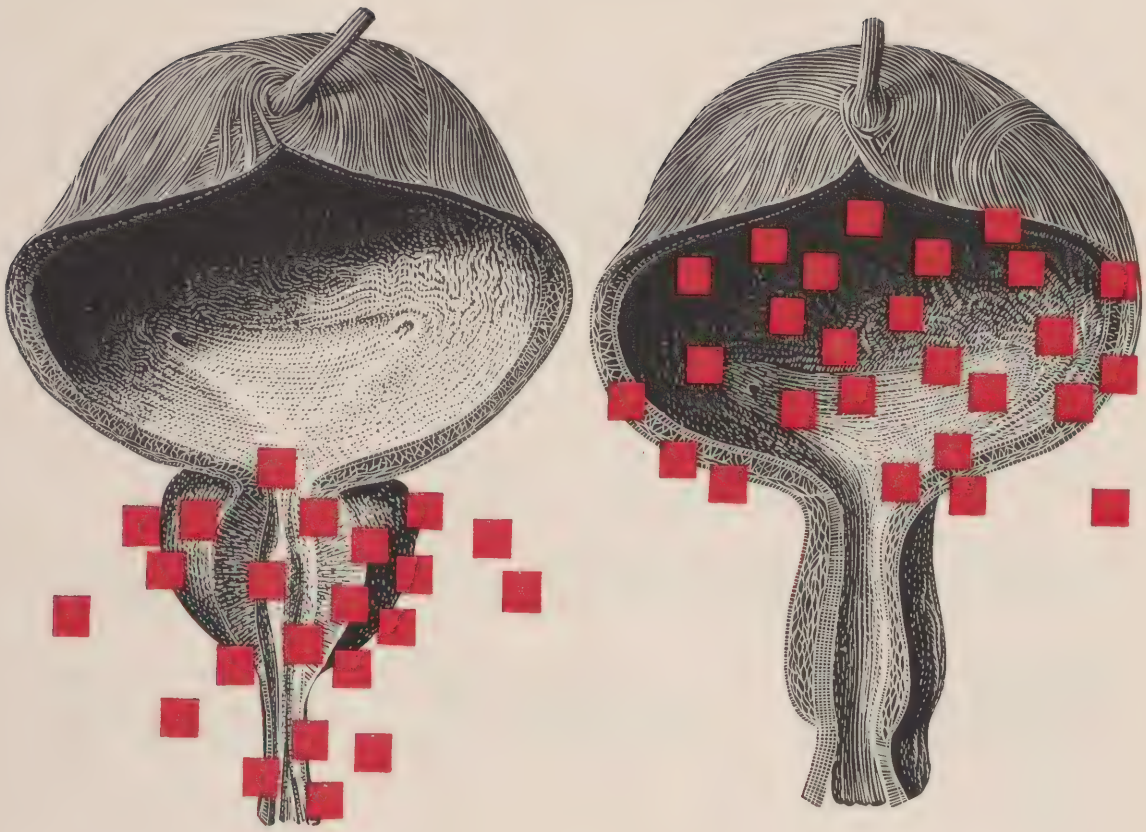
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the most common pathogens
respond to



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References: (1) Katz, Y. J., & Bourdo, S. R.: *Pediat. Clin. North America* **8**:1259, 1961. (2) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Whitaker, L.: *Canad. M. A. J.* **84**:1022, 1961. (6) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959.

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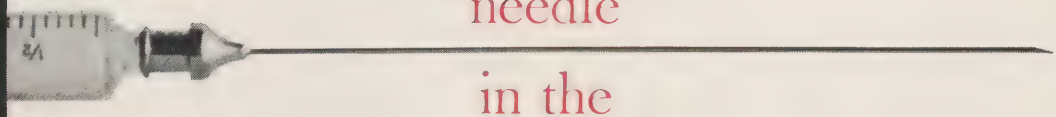
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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1. Meyers. G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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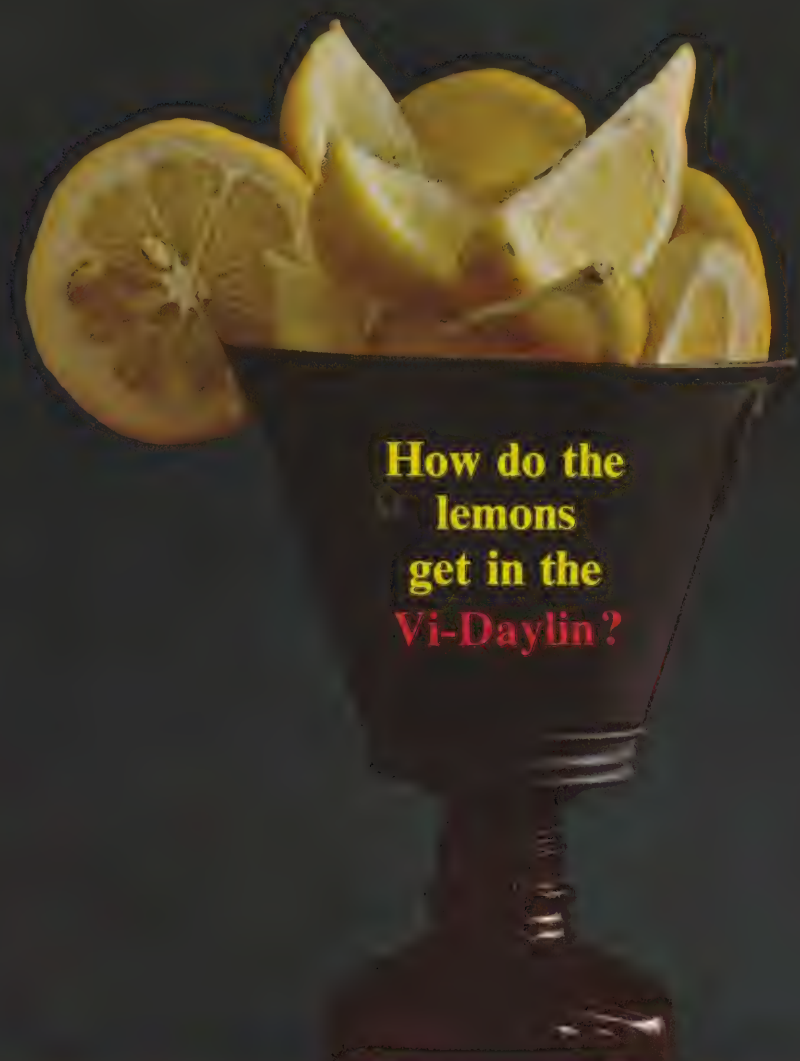
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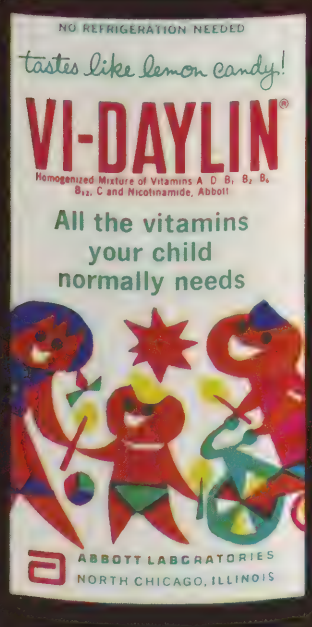
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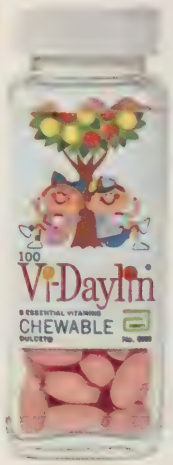
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North Chicago, Illinois

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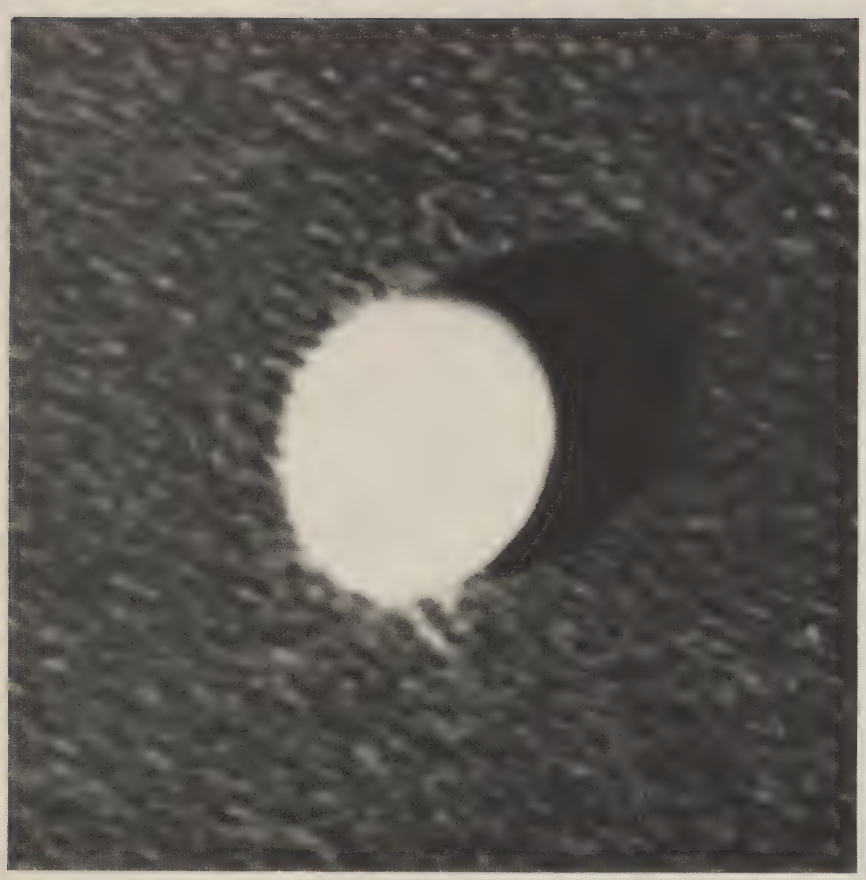
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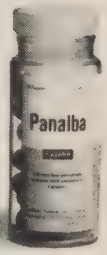
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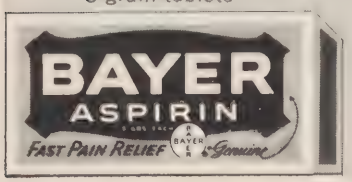


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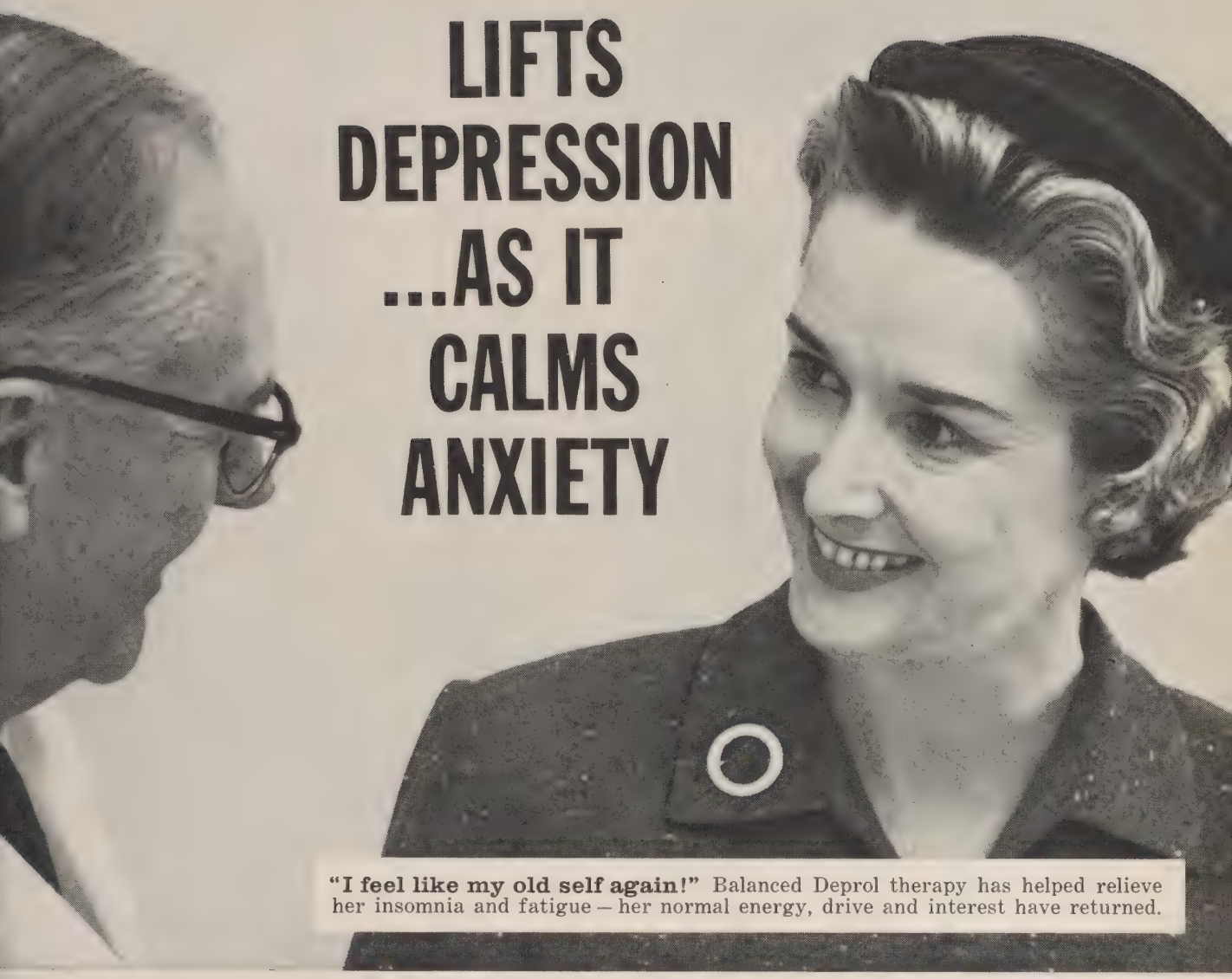


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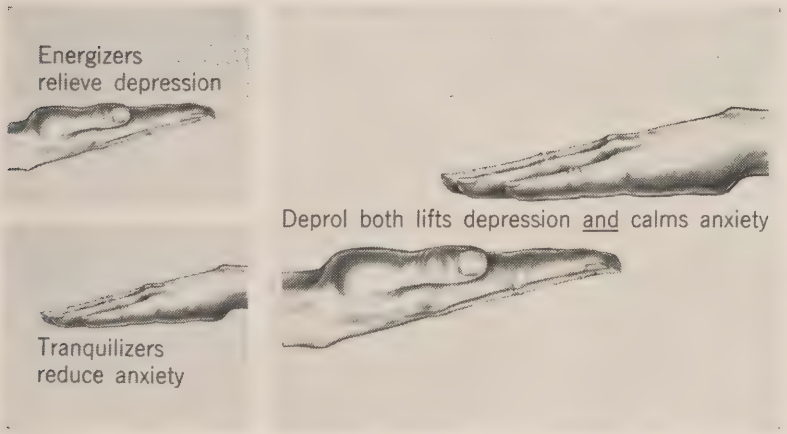
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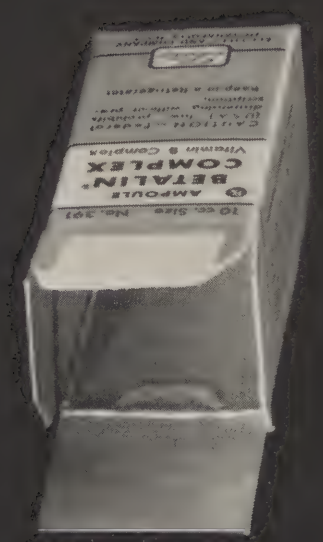
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SEPTIC SHOCK

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Septic shock is a term commonly applied to a poorly understood catastrophic combination of hypotension and sepsis. Its pathogenesis remains obscure in spite of intensive investigation. The onset can be sudden or subtle. Early recognition is essential for the survival of the patient. This presentation is a summary of the present concepts of etiology, diagnosis and treatment of sepsis and circulatory collapse.

Sepsis continues to account for a major portion of deaths on a surgical service. Septic shock is an end stage of infection and too often an irreversible condition. The term "septic shock" must remain a broad general term applied to disease states associated with sepsis and hypotension. The usual manifestations clinically are fever, chills, hypotension, tachycardia, and often syncope or coma. It can occur with any existing infection and is more frequent with peritonitis, peritoneal abscesses, urinary tract infections, and gangrenous bowel. Circulatory collapse associated with an infection is a grave prognostic sign. Unless the infection and shock are immediately treated vigorously, death usually occurs within hours.

At present, there is a mounting interest in this condition because of the therapeutic challenge that it raises and the too frequent dire consequences. The problem is an extremely complex one as it may be caused by many different organisms and different strains of the same organism. The fact that in some infections an endotoxin might account for the collapse of the patient and in others an exotoxin, with an entirely different chemical nature, may initiate this catastrophe further complicates investigative procedures. The mechanism whereby hypotension is finally attained probably varies with different types of sepsis.

Laboratory investigators can study individual physiological reactions to sepsis more specifically whereas clinically much must be left for conjecture in each case. Endotoxin shock can be readily reproduced in the laboratory animal but many of the changes brought about are not seen in patients. Irreversibility can be well defined in the laboratory but in the human, septic shock is reversible when the patient lives and irreversible when the patient dies. It defies further clarification. However, specific findings related to the laboratory animal such as

blood pH, vasomotor status, cardiac output, blood volume changes, plasma loss, capillary permeability, catechol amine levels, and tissue oxygenation studies are providing clinicians with a better basis for treating this condition.

The investigative aspect of septic shock is too vast and too complex a field for presentation here. The purpose of this paper will be to discuss septic shock from the standpoint of available therapeutic measures and the rationale for their use in attempting to reverse the catastrophic course of patients with infections and vascular collapse.

Two patients are presented. The success with these two cases in no way reflects our overall success with this problem. Other patients have been treated vigorously also but without survival. The two cases below demonstrated a definite reversal of a progressive deterioration with the institution of the regimen that we have adopted for treating septic shock. The fact that the first patient survived is truly remarkable and must be supportive evidence that some of these methods of treatment are vital to the reversal of this condition.

Case 1: M. S., an 11 year old W. M., was admitted to the Medical College Hospital on May 8, 1961 at 11:30 P. M. His mother stated that he had had abdominal pain for 5 days. Examination revealed a severely ill child. The pulse rate was 168/min., respiratory rate 52/min., and body temperature 104°F. Physical findings were consistent with generalized peritonitis. Roentgenograms demonstrated free air in the peritoneal cavity. Interestingly enough, the leukocyte count was 6,650 and the differential count was within normal limits. A blood specimen was obtained for culture but no organisms were grown. The patient had received antibiotics prior to admission.

A preoperative diagnosis of acute appendicitis with perforation was made and operation was performed 3 hours following admission. At operation pus escaped from the peritoneal cavity with pressure. Approximately 700 ml. of pus was aspirated from the peritoneal cavity. There was generalized peritonitis. An acutely inflamed, partially gangrenous appendix with a 2 cm. perforation in its midportion was removed. *Escherichia coli* organisms were cultured from the pus. A cecostomy tube was inserted through the appendiceal stump, and numerous drains were inserted. The closure of the skin and subcutaneous fat was delayed. Throughout the operative procedure, the pulse rate ranged 150-170/min., the respiratory rate ranged 50-60/min., and the blood pressure was fairly constant at 80 mm. Hg. systolic, 60 diastolic. An infusion of 500 ml. of whole blood elevated the blood pressure. Tachycardia and tachypnea persisted postoperatively. The temperature remained at 106° F. Diaphorsis was profuse. Large doses of antibiotics were given. On the evening of May 9 he again became hypotensive. A telethermometer was inserted into the rectum and body temperature constantly recorded. At this time the temperature was 110° F and remained so for several hours. The pulse rate was 160/min. and the respiratory rate 48/min. The pupils became dilated and fixed. Convulsions occurred frequently throughout the night. Urevert (sterile lyophilized urea) was given to reduce cerebral edema that could possibly have resulted from anoxia. There was no response. Urine output was scant. The lung fields remained clear to auscultation but the diaphragm was elevated bilaterally. The patient was placed in the refrigerator blankets and after 4 hours the temperature came down to 102° F. There was a moderate decrease of pulse and respiratory rates. Aramine (levarteronal bitartrate) was given as a vasopressor but was ineffective. An intravenous drip of a solution containing Levophed relieved the hypotension. During this time the patient received 100 mg. of hydrocortisone every three hours. Calcium gluconate was given in an effort to relieve hypocalcemia as a possible cause of central nervous system irritability. Serum electrolyte concentrations were maintained within normal limits. There was a moderate acidosis at this time. Two days later the acidosis was not present. A blood urea nitrogen reading obtained early in the morning of May 10 was 145 mg./100 ml. This gradually returned to normal during the next six days. By the evening of May 10, the patient was in better condition. Urine output was adequate. Body temperature was maintained at 102° by using the refrigerator blanket intermittently. The convulsions ceased and the patient began to respond to verbal commands. The tachycardia, tachypnea, and hypotension were much improved.

During the next few days, there was gradual but progressive improvement. Levophed and hydrocortisone were decreased by graduated increments. Hypothermia was used only to reduce fever above 103°. The patient continued to be quite ill for several months and had a peculiar generalized motor weakness. Because this involved the muscles of respiration, a tracheostomy and mechanical respirator were necessary. Complicating abscesses made the following procedures necessary.

May 29, 1961:	Drainage of left subphrenic and left flank abscesses.
July 10, 1961:	Drainage of right subphrenic, right flank, and left flank abscesses.
July 17, 1961:	Drainage of left subphrenic abscess.

He was finally discharged on July 26, 1961.

Several subsequent admissions were necessary for the following:

August 14, 1961:	Drainage lower abdominal abscess.
September 5, 1961:	Right ureterolithotomy.
October 25, 1961:	Lysis of adhesions and release of mechanical small bowel obstruction.

Comment: Many details of this unusual case have been omitted. Space permits mention of only the highlights. It is remarkable that this child survived. He is now enjoying excellent health and pursuing the normal activities of his age. There is no evidence of physical or mental retardation.

Case 2: C. W., a 36 year old truck driver, was admitted to the Medical College Hospital on June 30, 1961. He had had abdominal pain for one week. Examination revealed an acutely ill patient with a pulse rate of 132/minute and body temperature of 103° F. The abdomen was moderately distended and exquisitely tender. Muscle spasm was prominent in the right lower abdominal quadrant. Following initial supportive therapy, he was operated upon and a gangrenous, perforated appendix was removed. The perforated appendicitis was associated with a diffuse, purulent peritonitis. *Escherichia coli* was the predominant organism cultured from the pus. Drains were placed around the cecum and into the pelvis. The patient remained febrile for approximately ten days following the operation but was afebrile when discharged on the fourteenth postoperative day.

Frequent outpatient examinations were done because of residual induration in the pelvic area. This area was not fluctuant so there was believed to be a residual inflammatory mass which had not softened.

Rather suddenly, on August 2, the patient became acutely ill with high fever, shaking chills, and syncope. Hospitalization was accomplished immediately. Initial examination revealed a pulse rate of 160/minute, a body temperature of 103.6° and a blood pressure of 80 systolic, 40 diastolic. A blood culture was obtained but reported later as negative. He was taking antibiotics at the time for the pelvic inflammatory mass. The leukocyte count was 60,400. Serum electrolyte concentrations were within normal limits. He was immediately started on intravenous Terramycin, 500 mg. every 12 hours. Neosynephrine was given intravenously as a vasopressor but was ineffective. An intravenous drip of a solution containing one ampule of Levophed per 1000 ml. was then given which immediately elevated the blood pressure to within normal limits. Hydrocortisone, 300 mg. initially, and 200 mg. every 3 hours was given intravenously. The patient responded rapidly. Sixteen hours following admission, the body temperature was normal, and the pulse rate was 100/min. Levophed and hydrocortisone were progressively decreased. The blood pressure remained stable following discontinuance of the vasopressor. A pelvic abscess was drained and the subsequent course was satisfactory. The patient suffered a third degree burn at the site of the Levophed infusion.

Comment: It was our assumption that this patient sustained a sudden release of organisms into the blood stream. He had been seen as an outpatient only several hours prior to this acute attack and at that time did not appear ill and was afebrile. The sudden fever, syncope, and hypotension are consistent with septic shock.

Pathogenesis

The pathogenesis of septic shock remains obscure despite the numerous and intensive investigations directed toward understanding the mechanisms responsible for this severe form of hypotension. There are probably many different factors contributing to this circulatory failure which vary a great deal in individual patients. Most of the investigations carried out have been done in laboratory animals where a standard shock preparation is utilized. Usually this has been produced by infusions of endotoxin from Gram negative organisms. Although the circulatory state produced is comparable to the clinical state of septic shock, many more variables are present in the severely ill patient sustaining septic shock as a complication of some pre-existing disease. The laboratory investigations do allow repetitive studies which can be more accurately analyzed than is the case with the ill patient who suddenly becomes critically ill.

Hardy[1] has found that the irreversible shock of strangulation obstruction, produced in dogs, is due in large measure to massive bacterial invasion of the blood stream. Large numbers of bacteria can be cultured from the portal and femoral venous blood in animals which have had strangulation fluid injected into the peritoneal cavity. This, in part, supports the concept that a bacteremia is present during septic shock. Organisms cannot always be obtained from the blood stream in patients. Altemeier and Cole[2] proved bacteremia by blood culture in only 11 of 26 cases in which cultures were obtained.

Loss of fluid from the circulation will bring

about hemoconcentration and diminished blood volume. Fluid loss in these patients can certainly result from dehydration, vomiting, diarrhea, effusion or exudation into body cavities, and loss through capillary walls. Altemeier and Cole[2] suggest that peripheral circulatory failure may result from the direct action of bacteria or their products on capillary walls, the effect of a histamine-like substance or protein degradation products on the vascular tree, the direct action of bacterial toxins on the heart, the effect of bacterial toxins on the medullary vasomotor center or regional sympathetic ganglia, or the effect of hypoxia.

Lillehei and MacLean[3] have observed that the principal autopsy finding in dogs dying of either irreversible hemorrhagic or endotoxin shock is hemorrhagic necrosis of the mucosa of the bowel. It is their contention that this lethal effect is brought about by the ability of these endotoxins to act as potent sympathomimetic agents or to sensitize the animal to levels of endogenous sympathomimetic agents which are ordinarily not toxic. It is evident from their investigations that the sympathomimetic action of endotoxin on the bowel and its mesentery can create a profound degree of bowel ischemia leading to an increase in vessel permeability, plasma loss, and eventually irreversible shock due to bowel necrosis. It is of interest here that the two cases we have reported demonstrated no signs of bowel necrosis as neither had bloody stools nor diarrhea. This has not been a prominent feature in several other patients who died.

Rosenberg, Lillehei, Longerbeam, and Zimmerman[4] measured levels of histamine, serotonin, epinephrine, and norepinephrine in dogs subjected to endotoxin shock. They postulated that a temporary depletion of the peripheral catechol amine store occurred and that vascular instability progressing to vasodilatation, pooling, and decreased cardiac output are ultimately responsible for the appearance of shock. Direct tissue injury and plasma loss were also believed to be contributing factors.

The central and reflex effects of fever, hypoxia, pH changes, retention of metabolities, and arteriolar injury contribute to the loss of vasomotor control which is characteristic of hypotension associated with sepsis.[5]

It is probably true that all of the above mechanisms might play a part in septic shock but that in different patients with different types and degrees of sepsis, various mechanisms would play a dominant role. These investigations begin to lend some clarity to a most confusing clinical situation.

Pathologic Findings

Altemeier and Cole[2] collected the findings in 64 autopsies performed on individuals who died with sepsis and hypotension. A significant number demonstrated pulmonary edema. They believed that this finding was probably indicative of the overloading of the vascular system in an unsuccessful attempt to restore normal blood pressure by replacing blood volume. Only 5 of the 64 autopsies demonstrated lower nephron nephrosis, suggesting that renal function could be saved by prompt treatment directed toward restoring and maintaining a normal blood pressure. The adrenal glands were involved in only 6 of the 64 cases. Peterson and Krippaehne[5] found significant evidence of unresolved sepsis in the lungs, urinary tract, peritoneum, surgical wound, and soft tissues in 32 cases. Lillehei and MacLean[3] found liver congestion present both in dogs dying of endotoxin shock and in those surviving and later sacrificed. On the basis of this evidence, the role of the liver in causing irreversible endotoxin shock did not appear to be crucial.

Diagnosis

Certainly one of the most important factors in septic shock is early recognition. A delay of a few hours in diagnosis and institution of therapeutic measures often is the difference between death and survival of the patient. It can be difficult in a severely ill or traumatized patient to distinguish between the causes of hypotension and to attribute the clinical state of the patient to what might be an unrecognized infection.

Although there are many variations in clinical patterns of septic shock, the following are frequently present. Hypotension is usually

marked with systolic pressures between 60 and 80 mm of mercury. Tachycardia exists and may be in the extreme ranges of 150-200/min. The temperature is usually over 103° F. but in the late stages can be subnormal. The respiratory rate is increased. The skin, in most cases, is cool and clammy but infrequently can be found to be warm and dry. The patient usually appears cyanotic and demonstrates varying degrees of a disturbed sensorium. Restlessness and apprehension may give way to disorientation, delirium, lethargy, and coma. Urinary output is suppressed. The blood urea nitrogen rises and is associated with a mild to moderate metabolic acidosis. Leukocytosis is the rule with white cell counts recorded as high as 60,000 and leukopenia is the exception with counts downward to 2,000.

With the above, if one follows the criteria of making this diagnosis as outlined by Altemeier and Cole,[2] as follows, a high index of accuracy in diagnosis will be attained.

1. Sudden insidious development of unanticipated hypotension and other symptoms of severe circulatory collapse in a patient with fever.
2. The occurrence of shock in the absence of the usual causes such as hemorrhage or trauma.
3. The presence of serious infection whose presence may be obscured by masking of localizing symptoms by antibiotic treatment.
4. The presence of signs of vegetative endocarditis.
5. Failure of the state of shock to respond to the usual methods of treatment used for hemorrhagic or traumatic shock.
6. The presence of a high leukocyte count, usually 20,000 or more with a marked predominance of polymorphonuclear leukocytes and evidence of toxic granulation. (A very low leukocyte count may also be suggestive of an overwhelming infection.)
7. Sudden occurrence of the signs of shock in a patient with a known intra-abdominal abscess.
8. The presence of petechiae, unexplained delirium, ileus.

Treatment

One of the first lines of therapy must be directed toward replacement of fluid, electrolytes, and blood. Extracellular fluid loss can contribute greatly to the shock of sepsis. Vomiting, diarrhea, ileus, and gastro-intestinal fistulae are not uncommonly associated factors. Where there is sepsis in a serous cavity, massive quantities of fluid, electrolytes, and colloid can be lost resulting in reduction of the effective circulating blood volume. The circulatory inadequacy on this basis alone can give the same clinical picture as with true septic shock. Hardy[1] focused attention toward another derangement that must be corrected. The low salt syndrome manifested by the same clinical findings as seen in septic shock must be recognized and treated with hypertonic saline solution. Excessive skin losses of water-electrolyte may occur in the hyperthermic state, and unregulated renal losses may complicate adrenal insufficiency and renal disease.[5]

Massive antibiotic therapy must begin as soon as a blood stream invasion of organisms is suspected. The antibiotic should be a broad spectrum one until the organism and its drug sensitivity can be determined. The intravenous route is mandatory as absorption from the subcutaneous tissue or muscle will be poor.

There has been a great deal of controversy regarding the use of hydrocortisone in septic shock. We have used this in massive doses (100-300 mg. every 3 hours) believing that it is probably beneficial. There is little evidence that it does any harm when used for short term therapy. Very few patients with septic shock show evidence clinically or at autopsy of true adrenal depletion. In those few that do have adrenal insufficiency, certainly hydrocortisone therapy is essential for their survival. In those that do not have adrenal insufficiency (much the greater per cent) the hydrocortisone is given with the idea that it might in some way support the reticuloendothelial system. Another advantage is its antipyretic activity. Hardy[1] states that the use of hydro-

cortisone has not been impressive in his experience. Lillehei and MacLean support[3] its use clinically on indirect evidence that indicates that in some manner the animal is protected against the effects of prolonged vasoconstriction and the intensity of the vasospasm. Survival in dogs given intravenous epinephrine in high concentrations was increased by the pretreatment with hydrocortisone. If septic shock is in any way an immunological or anaphylactoid reaction as some investigators believe, the use of adrenal steroids might have a beneficial effect.[4]

Although experimental evidence shows that a marked vasoconstriction occurs during septic shock, vasopressors continue to be used clinically and in our own experience have been effective in raising blood pressure and increasing urinary output. Hardy[1] questions the use of vasopressors on an experimental basis but supports their use clinically. Altemeier and Cole[2] found Levophed effectively elevated blood pressure in all of their 45 cases temporarily. Peterson and Krippaehne[6] initiate vasopressor therapy with neosynephrine and reserve noradrenaline for those cases unresponsive to neosynephrine. Our own experience has been a very modest one but we have followed the routine of first giving neosynephrine and quickly switching to Levophed if the blood pressure shows no response to neosynephrine. There needs to be more investigation in this regard and eventually therapy might swing away from the use of vasopressors toward vasodilators if it can be determined that greater organ survival by increased blood flow can be achieved with the use of vasodilators (adrenergic blocking agents). As mentioned previously Rosenberg and associates[4] postulate that a temporary depletion of the peripheral catechol amine store occurs and that vascular instability progressing to vasodilatation, pooling, and decreased cardiac output eventually is responsible for shock. If this is true, the use of vasopressors would beneficially replace the depleted peripheral stores of the catechol amines. Vasopressors, like many other therapeutic adjuncts, can be detrimental to the patient if proper caution does not accompany their use. First of all, the infusion fluid itself must be limited in quantity and be a part of the patients calculated fluid requirement. The enthusiastic use of a vasopressor without regard to quantity of infusion fluid may cause an intolerable water load. Too much vasopressor or a highly concentrated solution of the vasopressor might have an injurious effect on the liver,[8] and might actually decrease urinary output by exerting a renal vasoconstrictor effect which would overcome hydrostatic pressure.[7]

There has been a mounting interest in the use of adrenergic blocking agents in the treatment of both hemorrhagic and septic shock. The purpose in using these agents is to block the sympathomimetic effect of the endotoxin which results in severe vasoconstriction and bowel necrosis in the laboratory animal.[1, 2] Increased survival rates have been obtained in dogs protected with Dibenzyline (phenoxybenzamine—HCl) when being subjected to endotoxin shock.[1] There has certainly been much hesitancy on the part of clinicians to use adrenergic blocking agents in the severely septic patient who has suddenly become hypotensive. If there is depletion of the catechol amine stores as postulated above,[4] the adrenergic blocking agents would have an adverse effect. There is a lot of security in seeing the blood pressure rise and urine output begin when effective vasopressors are used. However, this question should remain open until further investigation more clearly defines the pathogenesis of septic shock.

Another important factor is the reduction as quickly as possible of the severe hyperthermic state that exists in many of these patients. A great increase in metabolic demand, injury to the central nervous system, liver, and other vital organs occurs when there is marked unrelieved hyperthermia. Peterson and Krippaehene[5] advocate cooling the patient to normothermic levels rather than to extreme degrees of hypothermia. Sedation is given to control shivering. The rapid reduction of the extreme temperature in Case I with the refrigerator blankets must have been critical to

survival. Blair, Buxton, Cowley, and Mansberger[8] advocate reducing the body temperature to a sub-normal level. It is their belief that the metabolic requirement will be reduced and the tolerance to hypoxia thereby increased. This hypothermic state places the patient at a metabolic level commensurate with oxygen availability. Also, according to these authors, the cold pressor effect tends to elevate and sustain the arterial blood pressure. At levels of moderate hypothermia the efficiency of the myocardium is improved. They have found 32° C to be suitable and safe and call this the "augmented level of hypothermia." Their criterion for employing hypothermia is the failure to respond to intensive conventional therapy. Cockett and Goodwin[9] believe hypothermia effective as it probably protects the host by altering the growth rate of the invading organisms. Eleven of their 12 patients survived when treated with hypothermia in addition to conventional therapeutic measures for bacteremic shock.

Experimental evidence shows that the strength of myocardial contractions in dogs remains remarkably good until just before death but that there is a depressant effect of the endotoxin solution on the strength of contraction of the isolated rat heart.[1] There is little doubt that in the presence of sepsis, shock, and hyperthermia the normal and diseased heart will suffer. Severe tachycardia reduces diastolic filling time and cause a reduction in cardiac output. Insufficient coronary perfusion results from a diminished blood volume and prolonged hypotension. For these reasons the indications for digitalis therapy and other measures in cardiac support must be carefully considered in the patient with sepsis and shock.[5] The use of digitalis routinely in these patients is probably not indicated but an awareness of possible cardiac decompensation should be maintained.

Hardaway, Barila, Burns, and Mock[10] contend that intravascular coagulation seems to be the direct cause of both endotoxin and hemorrhagic shock. It is suggested that heparin might be of value in these states to reduce the intravascular clotting. Clinical support for this has not yet been obtained. This is another investigative finding which may enhance the therapeutic regimen of these patients when more fully explored. Low molecular weight dextran has been found experimentally to prevent sludging, thereby preventing coagulation in collateral venous channels.[11] This too might some day prove to be beneficial to these patients.

Other supportive measures such as oxygen therapy, and an indwelling urinary catheter for hourly assessment of urinary function are beneficial. If possible, the urinary output should be maintained at 25-50 ml./hr. with caution against overloading the circulatory system. Central venous pressures might be helpful when dehydration has been compensated and hypotension persist. Tracheostomy and mechanical respiration will be helpful to those patients with decreased respiratory function and poor respiratory reserve. A continuous search for areas of sepsis must be made and such areas of infection alleviated as soon as the patient's condition permits.

Summary

Septic shock is a catastrophic type of hypotension associated with a pre-existing infection. This accounts for a significant number of deaths on a surgical service. Because the pathogenesis is not well understood, therapeutic measures are still on a trial and error basis. The numerous investigations being conducted at present are gradually yielding results which are beginning to clarify the abnormal physiologic responses caused by severe infection. Two cases have been presented which survived. These two cases in no way reflect our overall experience with this problem. Some of the highlights of current investigative findings have been cited. Factors which would help in differentiating septic shock from other types of shock are discussed. The therapeutic measures that we have used in treating septic shock are evaluated from our own and others experiences. Newer concepts of treatment which may, in the future, be valuable are also mentioned.

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NUTMEG (MYRISTICIN) POISONING

A CASE REPORT

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The following case seems worthy of presentation because it illustrates a relatively rare form of intoxication, the manifestations of which may be dismissed by the unsuspecting examiner as an anxiety reaction.

Case Report

A 41 year old building contractor was admitted to the Medical College Hospital on January 22, 1962 because his physician feared that he might have an impending myocardial infarction. Because of a small pustule on his neck, he had for several days taken Fowler's Solution with potassium iodide (10 drops three times daily) prescribed by a pharmacist friend. Finally, a friend suggested that the ingestion of nutmeg might help his skin infection. On this advice, he bought several nutmegs from a grocery store and proceeded to eat two of these whole on the morning of the day of admission. That afternoon he noted some malaise and went to bed. His mouth seemed dry and he was mildly nauseated. He experienced feelings of warmth with increased perspiration. After sleeping most of the afternoon, he awoke feeling hungry and ate a large dinner. Following this, he felt as though "things were closing in," became weak and experienced a sense of impending disaster. He began to breathe more rapidly than normal, and noted vague, fleeting pains in his chest and left arm. These sensations recurred in episodic form at gradually shorter intervals. At one point, when the attacks were about two minutes apart, he felt certain that he would die. It was necessary that an ambulance be summoned to bring him to the hospital emergency room. Here he was noted to be anxious, hyperventilating and hypotensive with a systolic blood pressure of 80 to 90 mm. Hg.

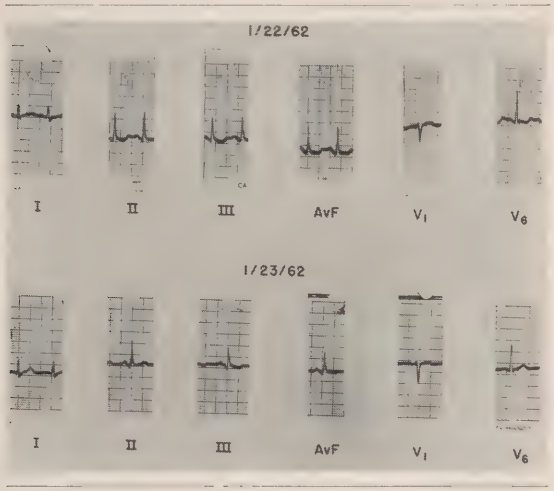
No immediate treatment was prescribed. By the time of arrival at his hospital room, he was much improved. Examination revealed a well developed and anxious man. Temperature 98°F. Pulse 118. Respirations 26. Blood pressure 120/60. Examination of the upper respiratory tract was normal. A small pustule was present on the posterior aspect of his neck. The heart and lungs were normal. The abdomen was relaxed and no organs or masses were palpable. There was no cyanosis and the temperature of the extremities was normal. The remainder of a complete physical examination was within normal limits.

His past health had been good except for an episode of hemoptysis four years previously which prompted hospitalization. Bronchoscopy and bronchograms done at that time were normal and he suf-

fered no recurrence of this disorder. He had been a heavy smoker and had always been "somewhat nervous," although he had never received treatment for any psychiatric disorder. There was a family history of diabetes.

Laboratory studies on admission showed hemoglobin 13.3 Gm., RBC's 5.5 mil., WBC's 10,800 (Polys 70%, Lymphs 26%, Monos 3%, Eos. 1%). Urinalysis negative. Fasting blood sugar 81 mg./100 ml. Blood cholesterol 205 mg./100 ml. Daily serum glutamic oxalacetic transaminase determinations on the three days of hospitalization were 17, 18 and 13 units respectively. Urine collected for 24 hours was negative for arsenic.

An electrocardiogram taken in the emergency room showed flattening and early inversion of T-waves with slight prolongation of the Q-T interval considered to be non-specific and compatible with changes seen with hyperventilation. An electrocardiogram the following morning was completely normal (Figure). A chest x-ray film was negative.



The patient remained afebrile throughout his hospital stay and his pulse slowed to a normal of 80 to 90 during the first 24 hours. By the morning after admission he felt well except for dryness of his mouth and he was anxious to return to work. His blood pressure remained stable between 110 to 130 mm. Hg. systolic and 70 to 80 mm. Hg. diastolic. No treatment was necessary except for bedtime sedation.

The admission impression was that of an acute anxiety reaction with electrocardiographic abnormalities secondary to hyperventilation. The possibility of an early myocardial infarction was considered less likely. The quantity of arsenic and potassium iodide ingested seemed too little to account for his symptoms, and his illness would have been dismissed as an anxiety reaction had not one of the authors recently read a description of nutmeg poisoning in children. This fortuitous recollection prompted a search of the literature which revealed descriptions of similar states following nutmeg ingestion and led us to conclude that our patient in all probability fell into this category.

Comment

A number of cases of nutmeg poisoning following the ingestion of one to three whole nutmegs or an equivalent amount of the ground condiment appear in the literature. The occasional misuse of this common kitchen spice has been the result of "old wives tales" describing its ability to induce abortion and to cure boils and various other conditions.

The essential oil of nutmeg and its chief toxic component is the phenolic compound myristicin (1 - allyl, 3 - methoxy, 4,5 - methylene dioxide benzene)[9-11, 12] This is a yellowish liquid with a specific gravity of 1.1425 and a boiling point of 149.5°C. Although nutmeg has been used medicinally in the past it appears to have little therapeutic value.

Dale[4] studied the toxic effects of whole nutmeg and myristicin in cats. Oral administration first resulted in vomiting, salivation and decreased appetite. These symptoms were followed in 2 to 3 days by the development of jaundice and coma, the loss of corneal reflexes, dilation of the pupils, slowed heart rate and respirations, decreased body temperature and finally death. Subcutaneous administration of myristicin produced similar findings with delayed death. Pathologic examination of these animals showed advanced fatty degeneration of the liver in all cases.

von Oettingen[12] reviewed the reports of toxicity in other animals including frogs, dogs, rabbits and guinea pigs, and noted a general depression of the central nervous system in all. Isolated guinea pig uterus showed some increased tone with the direct application of myristicin in Tyrode's solution. Isolated rabbit intestines showed decreased tone and a reduced number of contractions with similar treatment.

Myristicin toxicity in man is illustrated by the following cases reported in the literature: Beck[2] described two young women who ingested two ground nutmegs added to wine, hoping to induce abortion. Following ingestion

of the drink they experienced dyspnea, some loss of memory and drowsiness. Both were found unconscious with weak, rapid pulses. Later, some "motor disturbances" developed with further increase in the pulse rate. From this state both patients recovered fully in three to five days without residual effects.

Mendelsohn[8] reported the case of a young man who ate two to three pieces of ground nutmeg for eczema associated with varicose veins. Following ingestion he experienced muscle weakness, dyspnea, dryness of his mouth and loss of memory. Finally he fell into a deep sleep but he recovered the following day with only slight fatigue.

A second case reported by the same author was a woman with menopausal bleeding who ate three nutmegs. She presented with severe agitation, fine tremor, restlessness, delirium, cold extremities and a weak rapid pulse. She recovered in two days.

Hammond[6] reported a similar case of a woman who, following ingestion of a grated nutmeg, developed nausea and vomiting, dizziness, coldness, restlessness and substernal pressure. Her pulse was rapid and weak and her respirations shallow and irregular. She too recovered the following day.

In other reports[1, 2, 5, 7, 10, 13, 14] patients have consumed from one to three nutmegs and have experienced restlessness, dizziness, fear of death, coldness of the extremities, occasional nausea and vomiting, abdominal pain and precordial pain or oppression. These patients were often found to be extremely agitated, delirious, and dyspneic and have had weak rapid pulses, and decreased body temperature. On several occasions patients were found unconscious. Occasionally there was flushing of the face while at other times pallor with cyanosis of the lips and nails predominated. Rare cases have displayed facial and periorbital edema associated with flushing. It is interesting that of all the instances reviewed in which nutmeg was taken as an abortifacient, this effort was successful in only one patient. Even in this instance the role of nutmeg was open to question since the abortion followed the ingestion by a period of a month. In this review, we found no documental report of a fatality due to nutmeg ingestion, although such an occurrence in a child was mentioned by Dale.[4]

Thus it is seen that nutmeg, if taken in large enough quantities, is toxic for man and animals. In man, because of a more sensitive nervous system, neurotoxic effects are more pronounced and occur at low concentrations, while in animals (including cats), the nervous system is less susceptible, and doses of myristicin sufficient to produce minimal neurotoxicity usually lead to delayed death due to liver failure.

In the cases reported, myristicin toxicity appears to have resulted primarily from a central nervous system depressive effect with periods of stimulation and associated respiratory and cardiovascular difficulties. Occasional case reports have suggested a possible hypersensitivity reaction as illustrated by the presence of facial and periorbital edema with flushing.

Although we cannot be dogmatic, we feel that the symptoms displayed by this case were sufficiently similar to those reported by others to warrant the conclusion that our patient suffered from mild nutmeg (myristicin) poisoning. It is hoped that this brief review may serve to increase the general awareness of this rare but interesting disorder.

Summary

A case of poisoning due to the ingestion of nutmeg is reported. The toxic component of nutmeg is the chemical, myristicin. The toxic effects of this compound in man and animals have been reviewed. Nutmeg, if ingested in sufficient quantities, can produce distressing and serious disturbances in man.

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Requests for reprints to Dr. Jervey, Dept. of Medicine, Medical College of South Carolina, 55 Doughty St., Charleston, S. C.

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MANAGEMENT OF ALCOHOLIC WITHDRAWAL

OBSERVATION USING CHLORDIAZEPOXIDE AS CHIEF TRANQUILIZING AGENT

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The management of symptoms of acute alcoholic withdrawal may be difficult and is usually complicated by problems of nutrition, gastric irritability, imbalance of electrolytes, central nervous dysfunction and psychiatric abnormalities. Because alcoholism is a multi-faceted medical problem, there is no single "panacea" drug available for the management of the withdrawal symptoms. Among the medications and therapeutic regimen that have been reported beneficial in the management of withdrawal from alcohol, chlordiazepoxide (Librium) has been recently singled out as an outstanding adjunct to therapy.[1-5]

This study concerns our experience with chlordiazepoxide as the chief tranquilizing agent in the management of 35 consecutive alcoholic patients hospitalized during the acute withdrawal period. The duration of pathologic drinking and the length of individual alcoholic bouts for this group is tabulated in Tables 1 and 2.

TABLE 1
Duration of Pathological Drinking

	1 year	1-3 years	3-5 years	5-10 years	10-20 years
# Patients	9	6	11	5	5

TABLE 2
Duration of Present Bout

Weeks.	Under 1	1	2	Over 2
# Patients	6	15	5	9

Method: Upon admission to the hospital, each patient was given intravenously 1,000 ml. of Baxter's #2 electrolyte solution to which was added a multivitamin preparation. In addition, patients were given initially chlordiazepoxide 100 mg. intramuscularly, reinforced when necessary with promazine or chlorpromazine 50-100 mg. intramuscularly. The latter was given in instances of extreme agitation, belligerency and situations not quickly brought under good control with the chlordiazepoxide initially given. For the first 24 hours chlordiazepoxide was continued as intramuscular medication, 50-100 mg. every 3-4 hours; later this same dosage was continued as oral medication, being maintained as long as psychomotor agitation and coarse tremor were observed. As the patient improved, the dosage and frequency of administration was gradually diminished. Parenteral vitamins

were continued daily and a full diet was begun as soon as the patient desired and tolerated it. This treatment was discontinued after 3 or 4 days or when the danger of hallucinosis or delirium tremens had passed.

Results

The results of this study are summarized in Table 3. Of specific interest was the

TABLE 3
Response of 35 Patients to Therapy

Signs & Symptoms	Day of Admission	Hours After Admission				
		24	48	72	96	120
Agitation	22	8	5	2	1	1
Excitement	12	1	1	1	--	--
Tremor	21	16	8	5	1	1
Disorientation	10	1	2	2	1	--
Delusions or Hallucinations	5	3	2	1	--	--
Uncooperative	10	3	3	1	--	--
Vomiting	9	1	1	--	--	--
Eating	1	27	33	35	--	--
Sleeping	11	26	34	35	--	--

prompt subsidence of agitation and excitement in most patients within the first 24 hours of treatment. Disorientation and hallucinations subsided promptly within 24 to 48 hours after admission, and excitement was much improved in most instances within 2 days after treatment was begun. Considerable improvement in appetite was brought about promptly by the administration of chlordiazepoxide. It was most interesting to observe that on admission only one of the 35 patients would eat, whereas after the first 24 hours, 27 of the 35 resumed full diets. After 72 hours, all patients were eating a full hospital diet. Tremor was poorly responsive to therapy and persisted even after 3 or 4 days of treatment. Agitation, excitement and vomiting were quickly brought under control with the treatment as prescribed.

Comment

In keeping with previous reports, parenteral chlordiazepoxide administered either intramuscularly or intravenously in the acute post-alcoholic patients seemed effective in promoting rapid control of agitation, excitement and disorientation. This response was not entirely consistent, however, since some patients did not show the same effectiveness of control as did others, even though the dose was increased and given at more frequent intervals. In these instances, other preparations (i.e. promazine or chlorpromazine) used in conjunction with chlordiazepoxide seemed to provide a more satisfactory clinical response. The most effective dose of chlordiazepoxide was found to be 25-50 mg. parenterally every 6 hours, or 25-50 mg. orally every 3-4 hours. No harmful side effects were observed in the 35 patients studied.

Summary

(1) Thirty-five alcoholic patients were hospitalized in the acute withdrawal period and given chlordiazepoxide as a chief tranquilizing agent. (2) Observations were made as to agitation, excitement, tremor, disorientation, delusions, hallucinations, cooperativeness, eating, vomiting and sleeping. (3) The duration of pathologic drinking varied from 1 year to 20 years and the duration of the present bout varied from 2 days to over 2 weeks. (4) Results were generally satisfactory with the prompt subsidence of agitation, excitement, disorientation and vomiting in most patients. (5) Tremor did not respond well to therapy and persisted for several days despite continued treatment. (6) No harmful side effects were observed.

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ESOPHAGECTOMY FOR BENIGN LESIONS

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Lye strictures of the esophagus are particularly disabling and difficult to handle. Three patients with chronic lye-stricture obstruction have been treated successfully by total esophagectomy and reconstruction with an interposed colon segment.

Many esophageal lesions present obstacles to successful removal and subsequent reconstruction of a satisfactory swallowing avenue. The previous dismal outlook for esophageal cancer, combined with the fact that in South Carolina carcinoma of the esophagus is the leading cancer in the colored male, have prompted an aggressive approach to the problem. This combines preoperative x-ray therapy and total esophagectomy performed in one stage three weeks later. Thus far early results are encouraging and are the subject of a separate group of reports.[2,]

Utilizing experience gained in treating esophageal cancer, attention has been given to benign afflictions such as strictures from ingestion of caustic agents. In spite of the availability of various commercial cleaning agents, sodium hydroxide, or lye, still is used as a household cleanser. It is usually kept in a glass jar and children and occasionally adults ingest the solution, mistaking it for milk. Severe stomal and esophageal burns result. With healing, fibrosis occurs and usually leads to some degree of esophageal obstruction. After dense scar has occurred, the usual sequence is gastrostomy, passage of a lead shot and string, and then retrograde dilatation with bougies. The dilatations are done at various intervals, usually for many years.

In spite of repeated bouginage over a period of years, three patients recently continued to experience high-grade esophageal obstruction due to scar. They were compelled to gastrostomy feeding. To accomplish dilatations a string was left constantly in place through the nose, down the esophagus, and out through the gastrostomy opening. One patient could not swallow her own saliva because of complete obstruction.

Recently three such patients with esophagageal stricture due to lye burns have been treated by single stage esophagectomy and reconstruction of the esophagus, using colon. A brief review of the cases is offered:

Case 1: A fifteen year old colored male at age 5½ years (1951) ingested lye and sustained esophageal burns. He was admitted to the hospital for gastrostomy and retrograde dilatations. After discharge periodic dilatations were performed and in 1956 barium swallow showed a long expansile stricture of the esophagus. In October 1957 he was swallowing well and the gastrostomy was closed. Two months later he swallowed an orange seed and was admitted because of esophageal obstruction. Esophagoscopy revealed a stenotic segment in the upper thoracic esophagus through which a #18 dilator could be passed. Barium swallow showed the stricture to be 7 cm. in length with a diameter of 3 mm. at the narrowest portion. He was discharged to continue antegrade dilatations. In August 1959 he had esophagoscopy to evaluate obstruction after choking on chicken meat. The upper thoracic esophageal stricture was again noted and dilatations resumed. In June 1961 he was able to swallow only liquids. Barium swallow showed a 5 cm. constriction with the narrowest point 1 to 2 mm. in diameter (Figure 1.) In July 1961 exploratory thoracotomy revealed a stricture too long to be resected and reconstructed with primary



Figure 1

Lateral view barium swallow showing the stricture in the mid-esophagus with dilatation of the proximal esophagus.

anastomosis. The entire esophagus was resected and a segment of transverse and left colon interposed between the cervical esophagus and the stomach. The ends of the remaining colon were then reapproximated. The postoperative course was uncomplicated and he was discharged on the 16th postoperative day. Since then he has been followed in the clinic and has been gaining weight and doing well. He swallows without difficulty. (Figure 2.)

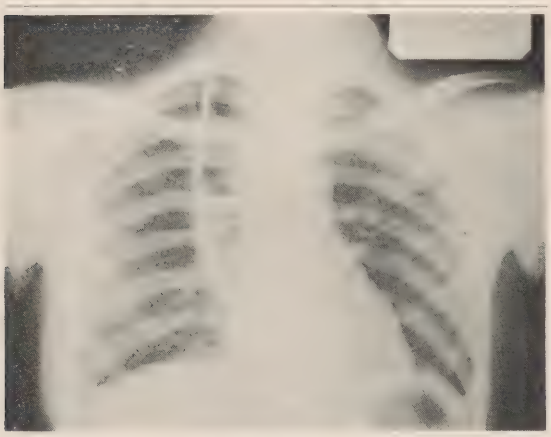


Figure 2

Postoperative barium swallow with the colon segment outlined and located just to the right of the sternum.

Case 2: A sixty-eight year old colored female was admitted with a history of accidental lye ingestion in June 1961. She sustained oral burns which soon healed. One month later progressive dysphagia appeared and shortly afterward, complete esophageal obstruction. A gastrostomy was performed but a lead shot could not be passed into the stomach. She was discharged on antegrade dilatations with a mercury-filled bougie and followed in the clinic with no further improvement. She was then admitted to the surgical service. Esophagoscopy disclosed a tight stricture 1 cm. below the crico-pharyngeus muscle.

Hypaque (Sodium Diatrizoate) swallow showed an additional totally-obstructing stricture in the mid-esophagus. The proximal constriction was dilated by passing a small Foley catheter through the stricture, inflating the Foley bag, and withdrawing the catheter. The amount of bag inflation was gradually increased until the stricture was dilated enough to allow passage of an esophagoscope. Meanwhile high protein, high caloric feedings were given by food pump through the gastrostomy. Esophagoscopy was performed after the proximal constriction had been traversed and the dense, unyielding lower stricture was met in the cervical esophagus.

Since dilatations could not be applied to the lower stricture, total esophagectomy and colon substitution were performed through simultaneous right neck, right chest, and abdominal incisions. The postoperative course was uncomplicated and the patient took water by mouth on the sixth postoperative day. She was discharged on the 18th postoperative day swallowing a regular solid diet well. The resected specimen showed an irregular dense, firm scar tissue stricture obstructing the distal one-half of the esophagus. (Figure 3.)

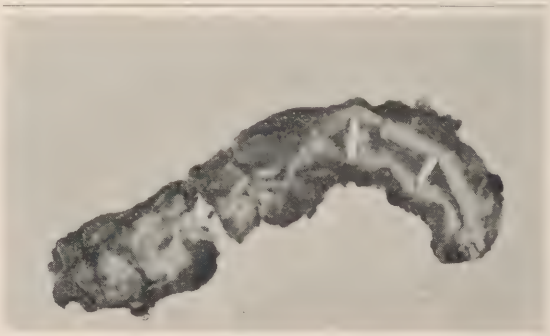


Figure 3

Resected esophagus showing the long dense stricture and thickened walls.

Case 3: A seven year old colored male was admitted to the Medical College Hospital on Feb. 19, 1962 with a history of lye ingestion in May 1959. He had been treated with gastrostomy and esophageal dilatations. Followup barium swallow showed a posterior perforation of the esophagus at the level of T-4 to T-6. The perforation healed on conservative therapy and the patient was followed in the clinic with frequent esophageal dilatations. He did well until three months prior to the last admission when he could swallow only liquids. Barium swallow showed practically complete esophageal obstruction at the aortic arch level.

On Feb. 26, 1962 exploratory thoracotomy revealed

a markedly strictured esophagus from the lower cervical level down to the distal third of the esophagus. The most prominent stricture extended distally from the lower cervical esophagus for 10 cm. A total esophagectomy with colon replacement was done in a manner similar to the previous two cases. Figure 4 schematically illustrates transposed colon.

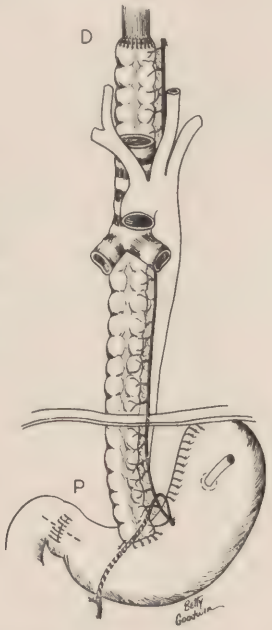


Figure 4

Final antiperistaltic scheme of esophagocoloplasty (D= distal; P= proximal colon). Colon segment in esophageal bed. Supporting middle colic artery passes posterior to stomach. Pyloroplasty and temporary gastrostomy are done.

The postoperative course was uncomplicated and a Hypaque swallow showed redundancy of the colon segment in the chest with some delay in passage of fluid into the stomach. Fluids were given and retained on the tenth postoperative day. The patient was discharged on the 19th postoperative day and was eating a regular diet. The redundancy remained but barium passed readily into the stomach without delay.

Discussion

Total esophageal resection with interposition of a segment of transverse and descending colon between the cervical esophagus and the stomach, performed in a single procedure, is becoming a safe and acceptable operation. We believe this approach to be preferable to the by-pass procedure, in which colon is brought up beneath the sternum to the cervical esophagus. With the single-stage intrathoracic approach the esophagus and scar can be resected, and the colon placed within the natural esophageal bed where there is less danger of angulation. The scarred segment of esophagus is more susceptible to later development of carcinoma if it is left in situ.[1, 4]

Although benign esophageal strictures do not carry the life-threatening potential of esophageal carcinoma, patients afflicted with esophageal obstruction are quite miserable. They must be fed via gastrostomy; they carry containers to hold their expectorated saliva; chronic malnutrition is the inevitable result; and their chances of developing carcinoma of the esophagus in the scarred segment is increased.

The operative difficulties of total esophagectomy have been reduced by use of two surgical teams working simultaneously. It has been reported that the colon segment need not be redundant in children since the segment apparently grows with the child.[5]

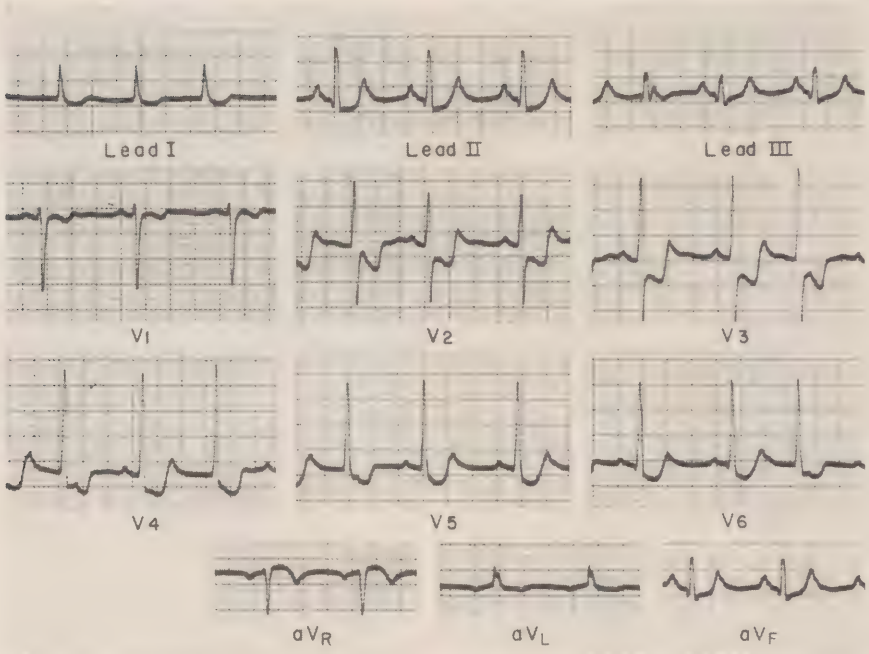
Summary

Three cases of successful resection of chronic lye strictures of the esophagus and replacement with colon segments have been reported. The surgical technique thus far found to be safe is a single-stage total thoracic esophagectomy and interposition of an isolated segment of transverse and descending colon. The procedure is performed by two surgical teams working simultaneously through separate cervical, right chest, and abdominal incisions. Esophagectomy removes the threat of later malignancy or infection of the strictured and scarred esophagus. Early restoration of swallowing is achieved.

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Clinics of the Month



ELECTROCARDIOGRAM OF THE MONTH

Obscured P Waves

DALE GROOM, M. D.
Department of Medicine

A perennial problem in electrocardiographic diagnosis of arrhythmias is that of P waves which are obscured in other complexes and hence go easily unrecognized. Illustrated here is a none too subtle example.

Case Record. This case is one of digitalis toxicity in a 57 year old lady hospitalized because of persistent nausea and vomiting of apparently psychogenic origin. As a consequence she had become dehydrated, dyspneic, with rales in the lung bases, had a moderate depletion of potassium (serum K 3.49 mEq) and a sustained sinus tachycardia. Following what would not ordinarily be an excessive dosage for digitalization (1.6 mg. Cedilanid intravenously over a period of 8 hours) her rate decreased to 110. Digitalis leaf was then given 100 mg. three times the next day when the rate dropped further and this tracing was recorded. The drug was then discontinued and she was given potassium intravenously, whereupon she reverted to a regular sinus rhythm. An incidental finding was that of a marked hypercholesterolemia without any evidence of occlusive disease in her peripheral arteries.

Electrocardiogram. At first glance the rhythm might appear to be a regular sinus one with unusual pointed P waves in several leads (e.g. II, aVF) and numerous premature beats, probably nodal in origin. Superimposed on the T waves, however, are other P waves spaced equidistant between the conducted ones, imparting a peculiar peaked configuration. The P-P interval measures out to be .38 second, a rate of 160. Rate of the ventricles is just half that.

The amount of S-T depression in the mid-precordial leads is more than one would expect from digitalis alone and suggests an element of subendocardial ischemia, possibly from the prolonged tachycardia.

Discussion. It is of course particularly important here to recognize the buried P waves because this arrhythmia, a paroxysmal atrial tachycardia with 2 to 1 block, is often a sign of a dangerous degree of digitalis toxicity. As to the arrhythmia, had the patient not been a little depleted of potassium from the vomiting, quite likely the amount of the drug given would not have evoked an atrial tachycardia. U waves are not unduly prominent in this or any of the patient's other electrocardiograms so that a significant hypokalemia was probably not suspected at the time of digitalization. Low levels of intracellular potassium do sensitize and predispose the myocardium to digitalis toxicity. Thus ominous arrhythmias such as this can appear in patients who have been taking the same dose of digitalis for months but have incurred a

potassium loss from vomiting, diarrhea or, more commonly, administration of chlorothiazide or other diuretics. Both atrial and ventricular muscle is so sensitized that arrhythmias which result from potassium loss are generally abolished promptly by administration of potassium with, of course, withholding of further digitalis.

When attention was first called to PAT with block as a common manifestation of digitalis toxicity this mechanism was estimated to account for about three-fourths of the observed instances of the arrhythmia.[1] Subsequent reports have revised downward the incidence to fifty per cent and less. Indeed, digitalis is indicated in the treatment of some cases of PAT with block to control congestive heart failure or to prevent a rapid ventricular rate by increasing the degree of AV block.[2]

So often the electrocardiographic diagnosis of an arrhythmia depends upon positive identification of P waves. If they are present, even though they may be of low voltage, recognizable deflections are usually inscribed in some lead, depending upon the electrical axis. The problem arises in the identification of these deflections when the timing is such that they are obscured in the larger QRS and T wave deflections. Thus when the heart rate increases the P wave may fall into the preceding T wave, atrial depolarization taking place almost simultaneously with ventricular repolarization. The same occurs with lengthening of the P-R interval or, as in this case, with a doubling of atrial rate whereby there are two P waves to each heart cycle, only one of which is conducted. Ventricular tachycardia of course completely obscures all P waves but their recognition there is generally of little more than academic interest.

A useful means of detecting obscured P waves in many types of arrhythmias is by the use of an exploring chest electrode placed in positions higher on the precordium than the conventional sites. For example, in the second and third interspaces around the sternum the electrode overlies the atria and P waves can often be clearly delineated with a little exploration. When that fails, an esophageal lead can usually be passed readily, placing its electrode directly behind and in very close proximity to the atria. Large P waves comparable in size to the QRS complexes of the limb leads can be recorded in that manner.

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POISON CASE REPORT OF MONTH
ACUTE NICOTINE POISONING

Henry W. Moore, M. D.
Columbia, S. C.

A two year, six month white male, son of a commercial nurseryman, became violently ill shortly after drinking an unknown liquid substance from a discarded soft drink bottle. A 4 yr. old playmate called the parents attention to the child's distress and the parents found the youngster comatose and convulsing. The patient was rushed to a nearby hospital in an estimated elapsed time of 15-20 minutes. He was dead on arrival.

Initially, the parents stated that the child had ingested malathion but subsequent investigation revealed that a 12 yr. old relative had filled the discarded bottle with "Black Leaf 40" and had left it under the house on a brick pier. The 2½ yr. old youngster later found the bottle and drank an unknown amount of its lethal contents. Black Leaf 40, a commercial insecticide, is composed of 40% alkaloidal nicotine. Nicotine is widely used as an insecticide and it is rapid in action and one of the most toxic of all known poisons. It is easily absorbed through intact skin, lungs and gastrointestinal tract. Forty (40) mg. is considered a lethal dose.

In severe poisoning following the ingestion of nicotine, the patient experiences immediate burning and discomfort in the mouth and throat. Salivation, nausea, vomiting and severe abdominal pain and diarrhea soon follow, Respirations become dyspnoeic and the breath develops a characteristic nicotine odor. Circulatory collapse, coma and convulsions frequently follow. Death may occur within a few minutes after ingestion of the poison. Some less severe cases develop coma, muscular twitchings, clonic and tonic convulsions and trismus. The pupils are constricted and amblyopia and other visual disturbances frequently develop. There may be profuse perspiration with cold and clammy skin and subnormal temperature.

In cutaneous absorption or inhalation poisoning the symptoms are generally less acute in onset, more protracted and the prognosis is more favorable.

TREATMENT

Consists of immediate removal of the poison because of the rapidity of its absorption. Thorough stomach lavage with permanganate solution or activated charcoal should be done. After stomach washing, charcoal or the universal antidote should be administered. Thorough and copious washing of the skin must be done in cases due to absorption through the skin. Artificial or supportive respiration may be necessary. Otherwise, treatment is mainly symptomatic and supportive.

This case again, reveals the hazard of exposing young children to extremely lethal poisons such as are found in practically all insecticides. The frequency of fatal poisoning of young children who drink carelessly stored and mishandled lethal poisons bespeaks loudly the inadequacy and lack of intelligence of adults. Let us safeguard our children by safely storing all known poisons. Under no conditions should one ever remove poisons from their original containers which carry proper labels and instructions regarding proper treatment when ingested. References: Poisoning—Von Oettingen—2nd Edition —Pages 452-53

Editorials

Planned Parenthood

For many years the principle of exerting some sort of control over the number of children born into the world has been well recognized and accepted by most clear thinking people. The quantity of talk now about the so called population explosion and the likelihood that if the present rate continues there will soon be standing room only in the world poses a serious need for rapid action in the field of planned parenthood. The pressing figures on the lack of food for the greatly increasing world population indicate that something must be done about the problem, and usually the best place to start any activity is at home.

Three South Carolina communities have been sufficiently impressed with the need for action to organize associations whose objective will be to disseminate necessary information and to promote the cause of selective parenthood. The original organization was in Kershaw County and this was followed soon afterwards by the Richland-Lexington County group, and then just a few months ago by an interested group of people in Beaufort County. These have all grown up since February of 1961, and the leaders in this movement are hopeful that it will spread rapidly over the state. They have adopted a sound exposition of their beliefs and goals, and they have had the approval and encouragement of many organizations including local and state medical bodies and the State Board of Health. Certainly medical organizations should endorse and promote this very excellent effort. Education through the doctor's office must be a vital part of the program, but it is also necessary that the public be informed that such advice is to be had and where it can be obtained, and that there is general professional approval of the whole movement.

Architectural Barriers and the Handicapped

For the man in the wheel chair, most of our buildings are about as easy to negotiate as is the Berlin Wall. Narrow doorways, flights of stairs, rest rooms not suitable for the disabled, narrow telephone booths, hazardous doorways all impose difficult barriers for the handicapped person.

A move is now afoot for breaking down these barriers. Sponsored in this state by the South Carolina Society for Crippled Children and Adults, it made an imposing appeal at a recent meeting in Columbia on October 19. It was pointed out that millions of people with heart conditions, people in wheel chairs, with heavy leg braces, or artificial limbs, not to mention the millions of aged people, would all benefit by rearrangement of construction so that easy accessibility by amply wide openings with ramps or other arrangements for entrance could be provided.

Many specifications have been devised for obtaining the desired ends and some buildings have already been constructed with the problem in mind. Public buildings particularly should be arranged to allow easy entry to the large element of people who need such special provision. This effort of the Crippled Children Society is very worthy and deserves to meet with great success.

Medical Education Loan Program

A far reaching new medical education loan guarantee program is now under way in American medicine. The goal of this program is to help eliminate the financial barrier to medicine for all who are qualified and accepted by approved training institutions. It is designed to provide a means of financing a substantial portion of the cost of a medical education.

The loan program for medical students, interns and residents is the result of a cooperative effort by American medicine and private enterprise.

The program is administered by the American Medical Association's Education and Re-

search Foundation. The ERF has established a loan guarantee fund. On the basis of this fund, the bank will lend up to $1,500 each year to students. The ERF in effect acts as co-signer. For each $1 on deposit in the ERF's loan guarantee fund, the bank will lend $12.50.

More than 3,300 students, interns and residents have borrowed more than $6,000,000 through this fund since it was started last February. South Carolina had 19 beneficiaries in medical school and one in hospital service for a total of $24,500. Physicians and others have contributed almost $700,000 to the loan guarantee fund, which makes these loans possible.

The guarantee fund is almost depleted and more money is needed immediately to keep up the program. Eventually it will become self-sustaining as loans are repaid, but right now substantial financial help is needed. Your check to the AMA-ERF, 535 North Dearborn St., Chicago, will help to keep this important program alive. Contributions to the Foundation are tax deductible.

Fluoridation

While the battle for fluoridation of municipal water supplies seems to be periodically won and lost in various communities, it is comforting to know that many towns in South Carolina have either added necessary material to their water or else enjoy a natural water fluoride content which obviates the necessity for artificial addition. The discussions and arguments on the virtues of fluoridation seem to have centered rather around political feeling than upon the convincing scientific evidence which indicates that fluoridation is an extremely valuable measure.

The list below indicates the communities which have adequate fluoride for the preservation of children's teeth, either naturally or by deliberate addition, and it is to be considered that additional individual administration of fluoride would be unnecessary and unwise. The communities not listed apparently all have less than the desirable 0.7 ppm., and supplemental fluoride might be desirable for individuals until these chemically backward areas wake up to the desirability of the simpler and far more effective method of administration.

(N = Natural, C = Controlled)

Aiken	C
Bishopville	C
Cayce	C
Cheraw	C
Chesterfield	C
Conway	N
Darlington	C
Fort Mill	C
Garden City	N
Georgetown	N
Glenn Springs	N
Hartsville	C
Hemingway	N
Ingrams Beach	N
Johnsonville	N
Kershaw Springs Mill	C
Kingstree	N
Lancaster	C
Loris	N
Marion	N & C
Monarch Mills	N
Moncks Corner	N
Mullins	N
Myrtle Beach	N
Ninety Six	C
Orangeburg	C
Pawleys Island	N
Rock Hill	C
Shivar Springs	N
Springs Cotton Mills	C
Sullivans Island	N
Timmonsville	N
Union	C
Walterboro	N
Windy Hill Development	N
Winnsboro	C

Image

Someone has posed the question whether we physicians are letting the television heroes down by failing to come up to their accomplishments. Ben Casey, Dr. Kildare, and others are considered to be important factors in maintaining a satisfactory image of medicine in the minds of millions of people who see them on the screen.

Doctors and Striking

The current diatribes about Doctors and their right to strike, which one sees in so many of the popular magazines and newspapers, are really rather puerile so far as they concern the doctors of the United States. Members of the American Association of Physicians and Surgeons are pledged to have nothing to do with pay from the Federal Government for the treatment of their patients. They will refuse such payments. This does not mean that they will strike against their patients or refuse treatment. What they will do, and what the doctors of Saskatchewan were not allowed to do, will be to continue to take care of their patients on the same basis that they have always taken care of them, to wit, on a fee for service basis. This is we believe what the average American wants and it is what we doctors will deliver. Had the Canadian Government allowed the Saskatchewan doctors to do this there would have been very little trouble there. It makes absolutely no sense to keep talking about the right of doctors to strike. Whether they have this right is indeed a moot question, but in America it is a question that will not have to be answered unless Mr. Goldberg and his accomplices on the Supreme Court can alter the law of the land, something that the Court has certainly tried to do more than once in recent years. American Medicine under present laws will assure the public that there will be no lack of care for those who need it whether they can pay for it or not. This has always been the policy of dedicated physicians, and it will continue to be so, regardless of the editorial opinion of *Look, Time, Life, Post* or more important publications. As of now the American public is the recipient of the best medical care available in the whole wide world. Pray God that this will always be the case and that the practice of medicine in this country will always interest the highest type of student as it does even now.

J. W. Jervey, Jr., M. D.

MISCELLANY

Spray Poison: Thinking still about the dangers of promiscuous spraying with violently toxic substances, we are encourgaed to see in the *New England Journal of Medicine* that a recent legislative act in Massachusetts forbids the use of any aircraft for application of insecticides unless licensed by a special board. Furthermore, the board is charged with studying methods of application and use of pesticides and the effects thereof.

National Medical Association: It seems a pity that this Association still promotes the establishment of the Administration's proposition for providing medical care for the elderly through Social Security. At a recent meeting the matter was debated heatedly, but a strong endorsement was given to approval of the medical program which has been so violently opposed by the AMA and other bodies.

Keogh Bill: At this writing, the long delay of the passage of the Keogh Bill has been ended, and the President failed to exercise the expected veto. Since it was not killed in this humiliating fashion, it will allow doctors and other self-employed people to put aside funds free of income tax and intended for retirement benefits. Organized medicine has long supported this bill.

Ars Longa: It is comforting to see that the President of our Medical School has advocated to the members of the Academy of General Practice attention to the continuation, revival and improvement of the art of medicine. The fair haired boy of research has rather overshadowed his less dramatic brother of late, very much to the detriment of certain facets of the image of medicine. Now the question arises as to where the artists in the practice of medicine will be obtained to teach the art to the student. It would seem that they must come from practitioners of experience rather than from those who have never known anything else except the academic halls of medicine.

SOUTH CAROLINA MEDICAL ASSOCIATION

ADDITIONAL COMMITTEE APPOINTMENTS MADE IN LATE AUGUST, 1962:

COMMITTEE ON MENTAL HEALTH LEGISLATION

Dr. James B. Galloway, Chairman, 1513 Hampton Street, Columbia
Dr. Robert G. Thompson, 1209 North Fant Street, Anderson
Dr. Hyman Marcus, 511 Carolina Avenue, Orangeburg
Dr. Joe E. Freed, South Carolina State Hospital (P. O. Drawer 189), Columbia
Dr. James J. Cleckley, 55 Doughty Street, Charleston
Dr. Joseph J. Nannarello, 610 Pendleton Street, Greenville
Dr. Allen P. Bruner, 11 West Calhoun Street, Sumter

SPECIAL STUDY COMMITTEE ON MEDICAL EDUCATION

This committee has been appointed to study and report to Council the advisability of a permanent committee to study medical education and all state agencies having medical advisory committees.

Dr. Martin M. Teague, Chairman, 501 South Harper Street, Laurens
Dr. William O. Whetsell, 857 Holly Street, N. E., Orangeburg
Dr. O. B. Mayer, 1220 Pickens Street, Columbia
Dr. Charles R. May, 210 Market Street, Bennettsville
Dr. Henry F. Ross, 606 Pendleton Street, Greenville
Dr. Charles B. Hanna, 2 Catawba Street, Spartanburg

SPECIAL STUDY COMMITTEE ON INCREASE IN NUMBER OF COUNCILORS

The Reference Committee on Amendments to the Constitution and By-Laws recommended and the House approved that "the motion made by Dr. Gressette for the increase of Councilors from nine to fifteen in order to correspond to the new Judicial rather than Medical Districts, should be referred to a special committee and given further study, and resubmitted as unfinished business at the next session of the House of Delegates in 1963."

Dr. Francis C. McLane, Chairman, Ware Shoals
Dr. Benton M. Montgomery, 1400 Johnstone, Newberry
Dr. Carr T. Larisey, Hampton
Dr. Keitt H. Smith, 1 Medical Court, Greenville
Dr. J. Sam Garrison, 801 Mobley Street, Johnston

SPECIAL STUDY COMMITTEE ON INSURANCE

This committee has been appointed to communicate with the South Carolina Insurance Underwriters Association and invite action toward standardization of insurance forms and study a plan known as the "individual responsibility plan" which originated in the Los Angeles County Medical Association.

Dr. William T. Hendrix, Chairman, 408 Andrews Building, Spartanburg
Dr. Waddy G. Baroody, 376 West Palmetto Street, Florence
Dr. Raymond K. O'Cain, 880 Russell Street, S. E., Orangeburg
Dr. Sol Neidich, 1112 Craven Street, Beaufort

COMMITTEE ON FEE SCHEDULE

Dr. Harold Jervey, Medical Advisor for the Industrial Commission, has requested some advice on the Fee Schedule which was given by a committee composed of Dr. W. W. Edwards, Greenville, Chairman; Dr. Frank C. Owens, Columbia; Dr. J. A. Siegling, Charleston; and Dr. George Bunch, Columbia. This committee has been asked to reactivate itself and advise Dr. Jervey, or make recommendations as to how it should be done.

Dr. William W. Edwards, Chairman, 103 East North Street, Greenville
Dr. Frank C. Owens, 1319 Laurel Street, Columbia
Dr. John A. Siegling, 70 Ashley Avenue, Charleston
Dr. George H. Bunch, 1400 Barnwell Street, Columbia

ADDITIONAL COMMITTEE APPOINTMENTS MADE IN LATE SEPTEMBER, 1962:

COMMITTEE ON POLIO VACCINE

Dr. Julian P. Price, Chairman, 248 South Irby Street, Florence
Dr. Harold P. Jackson, 13 Medical Center, Greenville
Dr. Frances I. Doyle, Pyatt Memorial Medical Bldg., Georgetown
Dr. Gerald E. McDaniel, State Board of Health, Columbia
Dr. James A. Hayne, 300 Maple Street, W., Hampton
Dr. Swift C. Black, 110 West Harrison Street, Dillon
Dr. Charles R. Holmes, 1840 Hampton Street, Columbia

COMMITTEE ON NURSING EDUCATION

Dr. Samuel H. Huff, Jr., Chm., 801 North Fant Street, Anderson
Dr. Neil C. Price, 557 Carolina, N. E., Orangeburg
Dr. Paul F. Holcomb, 711 North Church Street, Spartanburg
Dr. Augustus J. Goforth, Jr., 709 Dunbar Street, Greenville
Dr. Jack C. Scurry, Scurry Clinic, Greenwood
Dr. George C. Smith, 311 West Palmetto Street, Florence
Dr. I. Grier Linton, 154 Wentworth Street, Charleston
Dr. Ragsdale Hewitt, 201 North Washington Street, Sumter
Dr. John M. Brewer, 206 South Matson Street, Kershaw
Dr. R. Cathcart Smith, 903 Bell Street, Conway

News

Dr. Parker Elected

Dr. Thomas Parker, nominated for President-Elect of the Association of American Physicians and Surgeons at the House of Delegates Meeting, April 7, was elected at the Annual Meeting, October 13.

S. C. A. G. P. Elects Dr. Cutchin

Dr. Joseph Henry Cutchin of Easley assumed the presidency of the South Carolina Academy of General Practice during the 14th annual scientific session held in Charleston September 28.

Dr. Cutchin succeeded Dr. Swift C. Black of Dillon.

Dr. William O. Whetsell of Orangeburg was selected president-elect for the state academy.

Other officers elected during the two-day meeting at the Francis Marion Hotel included Dr. Harold P. Hope of Union, vice president, Dr. William J. Bannen of Simpsonville, secretary, and Dr. John W. Blanton, Chesnee, treasurer.

Dr. Martin M. Teague of Laurens and Dr. George Duncan of Spartanburg were named to the board of directors. Dr. George Price, Spartanburg, was named a delegate to the 1963 national convention of the academy and Dr. William Stuckey of Sumter was elected alternate.

The state academy will meet in Columbia next year, October 10-11. Approximately 250 physicians, their wives, and exhibitors attended the 14th session.

Medical College of Georgia

Diagnosis and conservative treatment of orthopedic disease and injury, primarily in the ambulatory patient, will be the emphasis of the post-graduate course, ORTHOPEDICS IN GENERAL PRACTICE, to be held at the Medical College of Georgia, December 4, 5, 6, 1962.

Each course is acceptable for 18 hours credit by the American Academy of General Practice. Registration is limited to a small group for close faculty-participant communication. Registration fee is $50.00. Application can be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

Dr. Aycock Speaks

Dr. E. Kenneth Aycock of Columbia spoke before the Annual South Carolina School Food Service Association on the subject of "The Contribution of Nutrition to Child Health."

No Nurses

The Kershaw County Memorial Hospital's School of Nursing has been obliged to decline applications from student nurses because of the shortage of qualified instructors.

MEDICAL TELEVISION

Thursday and Friday, December 6th and 7th, 8-9:30 P. M. on South Carolina's Educational Television Network.

MANAGEMENT OF ACQUIRED HEART DISEASE

Panel:

Dr. George Clowes
Prof. of Surgery, Medical College of South Carolina

Dr. Donald B. Hackel
Prof. of Pathology, Duke University
Dr. Dale Groom, Moderator

Acceptable for 1½ Hours Category *I* Credit Each, American Academy of General Practice.

Family of the Year

Dr. J. Anthony White and his family of Easley have been named the 1962 Methodist Family of the Year from among more than 370 families selected by the Methodist districts.

Camp Elected by Piedmont Assembly

The Piedmont Post Graduate Medical Assembly has elected Dr. Ned Camp of Anderson its new president, succeeding Dr. Robert Burley of Clemson. Dr. John B. Martin, Jr., also of Anderson, was named executive vice president. Vice presidents chosen were Dr. Robert Brownlee of Greenville and Dr. Anthony White of Easley. Dr. Warren White of Anderson was elected secretary-treasurer and Dr. Charles Barnett of Clemson was named registrar. Dr. Camp, the new president, has been secretary-treasurer of the Assembly for seventeen years.

Gressette Speaks to Auxiliary

Dr. James H. Gressette addressed the Executive Board of the Auxiliary to the South Carolina Medical Association in September. He spoke of the contrast between the Kerr-Mills Act and the King-Anderson Bill.

Chesterfield County Memorial Hospital

A new wing which will bring the number of beds of the hospital to a total of seventy-two was scheduled for completion in October.

Spartanburg Auxiliary Hears Johnson

Dr. George D. Johnson of Spartanburg addressed the Auxiliary to the Spartanburg County Medical Society at the Country Club recently, discussing the several measures for medical assistance to the aged.

Medical Complex for S. C. U.

According to *The State* of September 27, 1962, at a recent meeting of the Columbia Medical Society the establishment of a basic science medical complex at the University of South Carolina was endorsed.

Greenville to Get Professional Building

Greenville Professional Building, a modernistic four-story medical building, is to be built on Vardry Street for occupancy by professional people.

Dr. Teague Talks in Spartanburg

Dr. Martin Teague addressed a group at Spartanburg on the subject of provisions for tuberculous patients in the state.

Chest Physicians Issue Statement on Cigarette Smoking

The Committee on Cancer of the American College of Chest Physicians for a number of years has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The members of the Board of Regents of the College are convinced that sufficient evidence has been accumulated to warrant issuing an official statement with regard to cigarette smoking and health. Accordingly, a resolution connecting cigarette smoking with various pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

The resolution stated that the weight of scientific evidence distinctly indicates that cigarette smoking and the inhalation of other atmospheric pollutants have an association relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases and cancer of the lung.

The College in its official statement urged its members and the medical profession in general to intensify their educational campaign directed toward the public, and the youth in particular, relative to the hazards of smoking.

The College urges that efforts to control atmospheric pollution be encouraged and that support be given to endeavors in the field of research for additional scientific information concerning other etiologic agents.

Hospital Closed

Hope Hospital in the textile town of Lockhart (population 4,000) has been closed. Its only physician, Dr. John A. McLeod, left last June to further his studies and since that time the Hospital Board has been unable to find a replacement although they offer a modern, 16 bed, completely air conditioned plant fully equipped with operating, X-ray, nursery, and office facilities staffed with an administrator and fifteen employees, plus a house, if need be, and even a medical bag. The Board's secretary has written various state and national medical authorities seeking their help in securing a doctor but thus far no doctor has been found.



Request Denied

The South Carolina Mental Health Commission requested $513,552 from the Budget and Control Board to pay for this year's operation of the Pineland School for retarded negroes, but the Board stripped $186,000 from the general fund requested by the Mental Health Commission and chopped another $39,000 from funds specifically requested for the Pineland operation.

Gaffney Clubs Hear Hospital Speakers

Dr. Rudolph Robert Steuer, Jr., Cherokee County Memorial Hospital pathologist, spoke at the August meeting of the Kiwanis Club in Gaffney, while on the same evening Dr. T. A. Campbell, Jr., head of the radiology department of the Cherokee County Memorial Hospital, addressed the Gaffney Lions Club.

Kilgore Addresses Rotary

Dr. Donald G. Kilgore, Jr. was guest speaker at the Rotary Club meeting held September 4 in Greenville. His subject was "What Socialized Medicine Means to You." He gave three reasons why the American citizen should oppose socialized medicine—impersonal medical care, cost, and the "dishonest" people involved.

Referral to the Medical College Clinics

It has been brought to the attention of the Medical College that many physicians in the state are unfamiliar with the process by which service patients are properly referred to the Out-Patient Clinic or to the In-Patient Wards. For a number of reasons the Medical College Hospital has left the responsibility for accepting these referrals in the hands of the Chief Resident physicians of the appropriate services. The chief resident of the appropriate service should be written to by title, or by name. A telephone call, of course, will also suffice. He can then reply as to the best method of the Medical College's handling the particular problem patient. The great pressure on service beds has made it extremely difficult to guarantee a reservation for Negro service patients in advance. For this reason every effort is being made to utilize the Out-Patient Department for as much of this work as is possible.

Attached is a list of the Senior Residents on the clinical services for the convenience of referring physicians.

Chief Residents

James C. Hughes, III, M. D. ----------Surgery
Travis B. Stevenson, Jr., M. D. ----------Surgery
William A. Cook, M. D. ----------Surgery
Bertrand V. Gue, Jr., M. D. ----------Medicine
Kenneth J. Parham, M. D. ----------Ob/Gyn.
George A. Sowell, M. D. ----------Ob/Gyn.
Jack T. Kakoury, M. D. ----------Radiology
Elwood Q. Seymour, M. D. ----------Radiology
James A. Cheezem, M. D. ------Orthopedic Surgery
William D. Hiers, M. D. ----------Neurology
Waddy W. Chapman, Jr., M. D. ----------Pathology
Anne D. Morgan, M. D. ----------Pediatrics

Hypertension Clinic At Medical College

A clinic for the investigation and treatment of patients with hypertensive disease has been opened at the Medical College. Its primary emphasis will be on the therapy of patients whose hypertension has not progressed to the development of irremediable crippling complications such as stroke, renal failure, or congestive failure. The clinic will attempt to establish whether intensive care of patients will increase their employability and improve their work records. As such, it is interested in relatively young hypertensives who are employed but who have quite apparent disease with consistent elevations of diastolic pressure.

The clinic will meet on Tuesday afternoons at 4 p. m. New patients should be referred to the Medical College Clinic at 1 o'clock on Tuesdays. Appropriate referral letters and requests for appointments should be directed to Dr. C. M. Smythe, Medical College Hospital, Charleston, South Carolina, or to Miss Virginia Bickley, Medical College Clinic.

Gynecologist Joins Medical College

Dr. H. Oliver Williamson has become a member of the Department of Obstetrics and Gynecology at the Medical College of South Carolina. Dr. Williamson completed his training in obstetrics and gynecology at the Medical Center Hospitals in 1961. For the past fourteen months he has been at Duke Hospital where he specialized in gynecological and obstetrical endocrinology.

Dr. Miller Opens Office

Edward H. Miller, M. D. announces the opening of his office for the General Practice of Medicine at 3310 Rivers Ave., Charleston Heights.



Architect's drawing of the new Oconee Memorial Hospital at Seneca.

Begin Emergency Medical Classes

An instructors' training class in emergency medical self-help was conducted by the Greenville County Civil Defense Council, in cooperation with the Greenville County Health Department in September.

Local Doctors Help Bloodmobile

Three local doctors were on hand to make the final visit of the Red Cross Bloodmobile to Allendale a success. Taking shifts throughout the day were Drs. A. B. Preacher, Luke Laffittee and W. R. Tuten.

Dr. Krueger Heads Hartsville Hospital Staff

Dr. Kenneth V. Krueger was elected chief of staff of Byerly Hospital at the annual meeting of the medical staff recently.

Dr. Charles H. Owens was elected vice-chief of staff and Dr. Griggs C. Dickson was elected secretary.

Miss Ringer Receives Scholarship

Miss Helen K. Ringer, a senior student at the Medical College of South Carolina, has been awarded a $1,000 scholarship by the Scholarship and Loan Committee of the College. The scholarship was made possible through the Medical College's participation in the Pfizer Laboratories Medical Scholarship Program.

Dr. Hester Presides

Dr. Lawrence L. Hester, Jr., Secretary, District IV, of the American College of Obstetricians and Gynecologists, presided at the General Session of the Annual Meeting of the Fourth District held October 5 in Charlotte, N. C.

Seventh District Medical Association

A meeting of the Seventh District Medical Association was held at the Elks Club, Sumter, on September 20, 1962. Participants in the program were Dr. Williams M. Bryan, Jr., Columbia; Dr. Saunders, Columbia; Dr. Charles A. James, Columbia; and Dr. John R. Harvin, Columbia. Retiring officers were: President, Dr. Haynes Barr of Sumter; Secretary-Treasurer, Dr. T. M. Davis of Manning; Vice Presidents: Clarendon County, Dr. E. W. Keller, Jr.; Georgetown County, Dr. S. E. Miller; Lee County, Dr. Leroy Dennis; Sumter County, Dr. James E. Bell; and Williamsburg County, Dr. James C. Montgomery.

S. C. Doctors Participate in S.M.A. Meeting

Physicians from many parts of the state were scheduled to participate in the 56th Annual Meeting ot the Southern Medical Association held in Miami Beach November 12-15.

Dr. John E. Mahaffey, Charleston, was scheduled as one of three panelists discussing "The Autonomic Nervous System in Anesthesia."

Dr. Lawrence L. Hester, Charleston, who was chairman of the Section on Gynecology, planned to address this section on "The Lost Decade."

Listed as speakers in the Otolaryngology Section were Drs. Richard Carter and R. W. Hanckel, Charleston, whose theme was "Epistaxis" and Dr. Paul Garrison, Greenwood, who was to discuss "Physiological Stapedectomy."

Two South Carolinians were to participate in the Symposium on Complications of Ocular Surgery: Dr. J. Howard Stokes, Florence, with a paper on "Flat Anterior Chambers Following Intraocular Surgery" and also as a panelist discussing "Complications of Ocular Surgery;" and Dr. J. W. Jervey, Jr., Greenville, as a panelist discussing "Complications of Cataract Surgery."

Dr. Frank H. Stelling, III, Greenville, was scheduled to discuss both "Spine Instrumentation in the Management of Scoliosis" and "Rib Resection in the Treatment of Scoliosis."

In the Section on Pediatrics, Dr. John R. Paul, Jr., Charleston, who was secretary of the section, was scheduled to moderate a discussion on "Chronically Handicapped Children" and Dr. R. Ramsey Mellette, Jr., Charleston, was to participate in the field of "Prevention of Noxious Iatrogenic Influences in the Chronically Handicapped Child."

Dr. Robert F. Hagerty, Charleston, was chairman of the Section on Plastic and Reconstructive Surgery. In this section Dr. Melvin H. Knisely, Charleston, was scheduled to speak on "Enforced Postponement of Selective Phagocytosis Following Burn;" Dr. C. Parker Meek, Aiken, was also to speak on burns, his theme being "Medical Debridement and Microdermagrafting of Burns," while Dr. James L. Hughes, Lancaster, was to speak on "The General Practitioner."

Dr. Hughes was to participate in the Section on Preventive Medicine as well, with a talk on "The General Practitioner's Role in Industrial Medicine." In this section Dr. Donald W. Sample, Fort Jackson, and Thomas G. Faison, Columbia, were also to be featured. They were to discuss "The Feasibility of of Routine Tuberculin Testing in Military Recruits with a Comparison of Various Methods of Performing Tuberculin Tests."

Scheduled to participate in the scientific exhibits was Harry T. Zankel of the Veterans Administration Hospital, Columbia, with an exhibit on Iontophoresis.

Civil Defense Emergency Hospital Shown in Dillon

A Civil Defense Emergency Hospital (CDEH) arrived in Dillon Sept. 18, 1962, for exhibition and training purposes.

The hospital facilities were used to train physicians and allied health personnel in techniques of setting up and operating the hospital, under the supervision of Doctor H. S. Gilmore, County Health Officer and Major Arthur A. Bushouse, Health Mobilization Representative, State Civil Defense Agency.

There are currently 26 CDEH units strategically prepositioned within South Carolina. Three of the hospitals are training units used for educational purposes. The remaining 23 hospitals are safely stored ready to be set up if a wide spread emergency should strike anywhere in the state.

Appointed By Governor To Serve On Mental Health

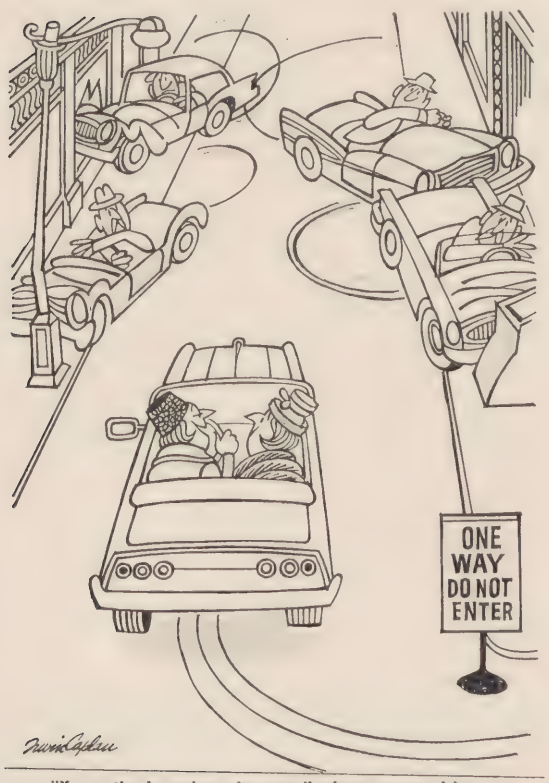
Dr. Martin M. Teague has received an appointment by Governor Ernest F. Hollings to serve as a member of the State Committee on Mental Health Board representing Laurens County.

He will serve on the committee until 1966.

He has been extremely active in Mental Health activities for a long period.

Dr. Hawkins Heads Professional Division Of United Fund

Dr. Randolph Hawkins is the chairman of the Professional Division for the coming United Fund drive in Union County. Today, he announced the names of those who will assist him with the solicitations. Working with accountants and attorneys will be David Russell. Dr. Palmer Fant heads the doctors group. Dr. V. H. Lipscomb will be responsible for the allied health field and Ralph Rogers the Nurses.



"You notice how they always talk about women drivers, but it's the men who have all the accidents."

Darlington Awaits CD Hospital Unit

The first allocation of the hospital emergency unit for Darlington arrived in September.

The materials amounted to about $20,000 in drugs, including medicines, bandages, dressings, and other items. There will be 70 cases of medicines in the first allocation.

Darlington already has on hand a 200-bed emergency hospital unit which can be set up and put into operation within a short time. There are generators on hand and many pieces of emergency equipment which are in storage.

Dr. Caston To Study At Duke

Dr. W. Frank Caston, clinical psychologist of the Whitten Village staff, will study electroencephalography at Duke University Medical Center this fall. He will participate in training on a part-time basis three days a week in the EEG Laboratory of the Department of Psychiatry.

Electroencephalography (EEG) is a new service which will be included in the hospital under construction at Whitten Village and one that will be of great benefit to many of the residents.

Preston Speaks At Annual TB Meet

Dr. John M. Preston of Columbia, director of the Richland County Health Department since 1952, was the speaker for the annual dinner meeting of the Marlboro County Tuberculosis Association, held October 30.

Ward Joins Staff At State Hospital

Dr. William F. Ward recently assumed his position on the medical staff of the South Carolina State Hospital with assignment to the medical-surgical service in the James F. Byrnes Clinical Center.

After receiving his preliminary education in the schools of his native city, Sumter, he attended Bob Jones University at Greenville for two years and later earned his B. S. degree from the University of South Carolina.

He was graduated from the Medical College of South Carolina in June, 1961, and completed a year's internship at the Columbia Hospital on July 1, 1962.

Medical College President Talks

Dr. H. Rawlings Pratt-Thomas, new president of the Medical College of South Carolina outlined modernization and expansion plans of the institution during a meeting of the Greeville County Medical Society at the Poinsett Club September 4.

He said the erection of a dental college, an increase in nursing school facilities and a complete medical library were among plans which will cost some $6 million.

When asked about the establishment of a two-year medical school, possibly at Furman University, Dr. Pratt-Thomas said, "We need physicians but we do not need a crash program. The problem at present is more one of distribution. I am afraid that if we start dividing up available state funds, we might well end up with two second-rate institutions."

Dr. George M. Fister, president of the American Medical Association, was also one of the featured speakers at the meeting.

Other speakers included Dr. Eugene Stead, professor of medicine at Duke University School of Medicine, Dr. George H. A. Clowes, surgery department head at the Medical College in Charleston and Dr. Joe Little, department of pediatrics at Vanderbilt University School of Medicine.

ANNUAL REPORT

Woman's Auxiliary to the South Carolina Medical Association

Mrs. John T. Cuttino, President

The Woman's Auxiliary to the South Carolina Medical Association has been ever mindful of the national theme for the year: "Speak Your Beliefs in Deeds" by "Letting the helping hands of the doctor's wife reflect and enrich the doctor's dedicated service to mankind." Sixteen auxiliaries representing 28 counties with a total membership of 917 adopted those projects which stimulate the interest and abilities of the members which meet the needs in each community.

We appreciate the patient guidance and assistance offered us by our Advisory Council and the Association President, Dr. Wyatt.

Legislation, perforce, took top priority in our concerns. The responsibilities of each doctor's wife on the legislative front have been emphasized by the President in her speeches to County auxiliaries and by the legislative chairman in frequent instructions to county legislative chairmen. The Ronald Reagan record is being played to anyone who will listen. The AAPS Essay Contest on "The Dangers of Socialized Medicine" has been sponsored. Congressmen have spoken at a few Auxiliary Meetings. The Washington *Newsletter* has been shared. Some study groups on legislation and socialized medicine have been held.

An Auxiliary by definition is a "helper", an "aid". Our recruitment program for allied fields of medicine provides positive assistance to our husbands. This is accomplished largely through sponsorship of 34 Health Careers Clubs and a two-day rally for the clubs. The chairman of the Health Careers Committee compiled and distributed a most helpful guidebook which furnishes a ready reference for club organization and material sources. The rally was well attended, registration of 280 numbering 80 more than the year before with boys attending for the first time. A splendid, varied program was arranged which included informative talks, films, film strips, exhibits, tours, and conferences in a number of fields of medicine. A workshop was held for sponsors and advisors to aid in strengthening the work of clubs and rally program. To further encourage students to choose health careers, loan funds and scholarships are maintained on both state and county levels. Four medical students are using loans of $1,000 a year each. Seven state and 10 county scholarships have been granted this year. Most of these are for $100 each. The Health careers, loan funds and scholarships are maintained administered by our Health Careers Committee.

To further the cause of medical education, $2,899,72 have been contributed to AMEF. This is an increase of $1,786.00. Greenville contributed $1,870.00 through its Christmas Card Project.

The Auxiliary is helping to conduct an effective, worthwhile, dynamic Civil Defense Program in our state. Twenty-six additional homes are reported prepared for emergency. Five fallout shelters have been constructed this year. Others are in the planning stage. Programs have included films, outstanding speakers, home preparedness workshops, setting up of emergency nursing programs, assisting doctors with setting up of a 300-bed emergency hospital for public display, setting up exhibits, distribution of pamphlets, attendance at seminars and workshops, serving as first aiders, preparing an exhibit for disaster preparedness.

There is no valid way of measuring accurate figures for hours spent in volunteer community service by our membership. The chairman says, "I wonder what would happen to a community if they took all the doctors' wives away." There is no organization—civic, health, welfare, youth—that we know of in the State of South Carolina using volunteers in which some doctor's wife does not participate. Besides service in organizations, auxiliaries collect drugs, collect medical text-books for medical missionaries, give assistance to hospitals, schools of nursing. In one county the auxiliary helped the doctors administer 63,000 doses of Sabin oral polio vaccine in a mass immunization "blitz" to combat an epidemic.

Over $500 has been contributed to the Association's Benevolence Fund and assistance has been given in finding worthy cases.

Since the change in format of the National Bulletin which now proves to be much more helpful to chairmen, 44 more subscriptions were obtained with 3 counties 100%.

All auxiliaries have participated in some sort of safety project. In one community using SWAT, out of 1,000 participants 600 became certified swimmers. "Seat Belts for every doctor's car" has met with splendid success. Pee Dee was awarded the Carol Lane award for Traffic Safety in its Pedestrian Safety



Bevy of beauties.



Serious reading.

Campaign. Poison control projects have been adopted.

Mental health is becoming the concern of more and more auxiliaries. Many Mental Health Centers are being established with auxiliary members playing a vital role in the process. Active projects are carried out with the State Hospital School for Mentally Retarded, Foster Care Homes, Senior Citizens groups, Rehabilitation Centers, classes for mentally retarded. The medical auxiliary was one of the few organizations in the state which had representatives at the Conference for the Aging in Charlotte.

Providing entertainment, manning registration desks, coffee breaks, clerical assistance at post-graduate seminars have proved to be very valuable helps to the county societies.

Working with the guidance of officers of the AMA Auxiliary, with other State Presidents, with my own State Board, with the County Auxiliaries—both large and small—strengthens my estimate that a doctor's wife possesses the most intelligence, alertness, and initiative of all ladies. It has been a privilege to serve this year with so many wonderful people.

EXCERPTS FROM—

THE ASSOCIATION OF CASES OF POLIOMYELITIS WITH THE USE OF TYPE III ORAL POLIOMYELITIS VACCINES

A Technical Report
by
Luther L. Terry, M. D.
Surgeon General, Public Health Service
U. S. Department of Health, Education, and Welfare
September 20, 1962

On September 15, 1962, the Surgeon General's Oral Poliomyelitis Vaccine Advisory Committee met in Washington, D. C. and reviewed the data concerning the occurrence of cases of poliomyelitis after the administration of oral poliomyelitis vaccines during the current calendar year. After a full discussion of the problem the Committee unanimously recommended that the use of Type III vaccine be limited to pre-school and school age children and to adults at high risk, i.e. those travelling to hyperendemic areas and those living in areas where Type III epidemics were present or impending. They advised that mass programs using Types I and II oral vaccines be continued for all age groups.

Since vaccine licensure, a great many community-wide vaccination programs have been carried out. The programs have ranged in size from those involving single small towns, to those which include metropolitan areas in several contiguous counties, to an essentially state-wide program in Massachusetts. The oral vaccines have also been employed for smaller programs among selected population groups and for routine use in private practice and health department immunization clinics.

In epidemic control, Type I vaccine was used immediately following release in the Syracuse, New York area and, in 1962, in many counties of Texas; in Mobile, Alabama; Pasadena, California; and several rural counties in Kentucky and Pennsylvania to abort existent or impending epidemics. Experimental lots of Type III vaccine were used in 1961 in outbreaks in Atlanta, Georgia, and in Newberry County, South Carolina. Commercial Type III vaccine was used in Washington County, Virginia, in 1962.

In most areas the vaccine was offered to persons of all ages and found wide acceptance among adults as well as children. In a few areas, as in Massachusetts, use of the oral vaccines in public programs was largely limited to children.

Present data indicate that for 1962, the paralytic poliomyelitis rate for those under 20 will be approximately 7.6 per million; for those over 20, about 0.9 per million. These rates will represent a record low for the 52 year period since the reporting began.

The further decline in the incidence of poliomyelitis in 1962 may be attributed to the steadily improved immunization status of the population resulting both from the continued use of inactivated polio vaccine and the wide use of oral vaccines.

The Occurrence of Cases Following Oral Vaccine:

With the licensing of Type I oral vaccine in August 1961, the poliomyelitis surveillance program of the Communicable Disease Center placed particular stress on the evaluation of reported cases of poliomyelitis developing after vaccine use. It was recognized that when millions of persons participate in an immunization program, any of a variety of subsequent events might occur coincidentally but be attributed erroneously to the vaccine. This could be particularly true of an intercurrent disease such as aseptic

meningitis that might simulate poliomyelitis and even poliomyelitis due to infection with wild polioviruses that had been acquired prior to the vaccination. The problem is compounded during the summer and early fall when many enteroviruses are actively circulating.

In epidemic control a number of cases of disease among vaccinees can be expected in the days immediately following an immunization program before there has been opportunity for immunity to develop. In nonepidemic areas, the frequency of coincidental cases should be lower, although not necessarily zero. If vaccine is related in a causal way to the cases, the intervals between immunization and onset of disease should group within the expected 7 to 30 day incubation period of the disease.

Since August 17, 1961, when Type I oral vaccine became commercially available, there have been 62 cases of poliomyelitis officially reported to the Public Health Service in which oral polio vaccine had been administered within 30 days prior to the onset of symptoms.

During the epidemic in New York State in 1961, a total of 32 "under 30-day vaccinated cases" was reported. Most of these developed soon after administration of the vaccine, in fact, 15 within 6 days. The early appearance of these cases indicates a coincidental rather than a causal relationship to vaccination. Similarly, in South Carolina, Georgia, and Texas, a total of 17 "under 30-day vaccinated cases" was reported. Again, most appeared soon after vaccination, 11 within 6 days, and do not suggest a causal relationship.

In the non-epidemic areas, a total of 16 "under 30-day vaccinated cases" has been reported. These have come from 7 states. Two followed Type I vaccine, one followed Type II vaccine, and 13 followed Type III vaccine. Eleven of the 16 occurred between the 15th and 29th day. This finding warranted further consideration of the possibility of a causal relationship to the vaccine particularly to the Type III vaccine.

Each case was considered individually, and excluded or not excluded by group decision from further consideration as to the possibility of its being vaccine induced. No case was excluded except by unanimous agreement of the committee members. Included for consideration were those cases clinically compatible with poliomyelitis which demonstrated any significant paralysis and in which laboratory findngs to date were not inconsistent with a vaccine relationship. Descriptive data regarding these cases are summarized in Table IV.

Of the two cases of poliomyelitis reported following Type I vaccine administration, only one (case 2) was thought by the Committee to be entirely compatible clinically with poliomyelitis. Of recent onset, the virologic studies on this patient are still in process. The clinical history of the other case (case 1) indicated it to be exceedingly mild and atypical. The patient experienced no known febrile illness, he was not hospitalized, and no cerebrospinal fluid studies were performed. He recovered with no residual paralysis.

The single case reported following immunization with Type II vaccine was found to have a Type III virus in his stool. Since Type III vaccine had not been fed, it can be concluded that the infection was due to a wild virus.

Eleven of the thirteen cases following Type III oral polio vaccine were considered by the Committee as possibly vaccine related. Of the two cases excluded, one (case 14) had an illness atypical for poliomyelitis with no functional impairment after 30 days. Both Type I and Type III polioviruses were recovered from the stool, 55 and 27 days respectively after Types I and III vaccines had been fed to the child. The Type I virus which was recovered was characterized as "wild-like" according to the results obtained by the modified Wecker and McBride tests. These tests are used to demonstrate slight antigenic differences between poliovirus strains of the same type. Since the virus strains may, after a period of intestinal multiplication, show such a shift in the antigenic characteristics of the viruses, no definitive interpretation of this finding was possible. The second case (case 16) which was excluded from further consideration had an insignificant paralytic residual and no detectable Type III antibody in either acute or convalescent serum specimens.

From 6 of the 11 cases, Type III poliovirus was recovered from stool specimens. Five of the six were characterized as "vaccine-like" by the modified Wecker and McBride tests. Although this finding was of interest, it unfortunately provided little help in determining whether the vaccine played a causal role. Each of these considered had been fed oral vaccine and, hence, might be expected to be excreting the Type III vaccine virus which might appear by the modified Wecker and McBride tests to be, as noted above, either "wild-like" or "vaccine-like." Further, it is possible that the oral vaccine strain may have displaced a "wild" enterovirus which was, in fact, the etiological agent responsible for the paralytic illness. In summary, isolation of a Type III virus from the stool and demonstration of Type III antibodies in the patient's sera served to indicate only that the paralytic disease would not be incompatible with Type III vaccine-induced disease.

The eleven cases considered as possibly related to Type III vaccine feeding are between 16 and 52 years of age, with all but three of the cases over 30. The vaccine administered to this group of cases was from several lots and was not produced by any single manufacturer. Of the 11 cases, 3 occurred in Oregon, 3 in Nebraska, 2 in Michigan, 2 in Ohio, and one in New York State. The clinical illnesses in these patients range from significant to severe. No deaths occurred. Among the eleven cases, the entire spectrum of non-fatal paralytic illness characteristic of poliomyelitis was evident.

Discussion Summary:

Of the reported cases to date, one following Type

I vaccine and eleven following Type III vaccine were considered by the Committee to be clinically consistent with paralytic poliomyelitis and with laboratory findings which could not exclude a possible relationship to the administration of oral vaccine.

As noted, a single case occurred within 30 days of Type I vaccine administration during a period of almost 9 months when approximately 20,000,000 persons were fed Type I vaccine. This is wholly compatible with coincidental origin.

The 11 cases following Type III vaccine cannot all be assumed to be coincidental. The adult age distribution ranging from 16 to 52 years with 8 of the cases over 30 years of age, and the clustering of the intervals from vaccine feeding to onset in the 2-3 week period suggest a vaccine relationship. For these reasons the Committee concluded that "there is sufficient epidemiological evidence to indicate that at least some of these cases have been caused by the Type III vaccines."

The incidence, assuming all cases to have been vaccine induced, is but 11 cases among more than 13 million fed. This is less than one case per million doses given. When the risk is related to age it is apparent that adults are exposed to a greater hazard than are children. Inadequate information on the age specific vaccine acceptance rate, however, makes it impossible to calculate a more precise estimate of the risk at this time.

With the incidence of poliomyelitis at a low level in this country, the Committee therefore recommended that the Type III vaccine be restricted to pre-school and school age children and to those adults in high risk groups, such as those travelling to hyperendemic areas or in areas where a Type III epidemic is present or impending.

Since the vast majority of poliomyelitis cases occur among young children and since children are the principal disseminators of the virus, continued intensive immunization programs among this group are clearly indicated. If this group can be adequately immunized, the spread of the poliomyelitis viruses will be sharply restricted, if not essentially eradicated.

THE MONTH IN WASHINGTON

Washington, D. C.—Influenced strongly by the thalidomide incident, Congress approved legislation giving the Food and Drug Administration more control over the prescription drug industry.

The Kennedy Administration and Sen. Estes Kefauver (D., Tenn.), chief sponsor of ethical drug legislation, successfully exploited the thalidomide incident after prospects of passage of a strong drug bill waned.

However, they were unable to get all they wanted in the legislation even with the impact on Congress of the widespread publicity about the clinical testing of thalidomide in this country coupled with reports from Europe of births of malformed children by women who had taken the drug during pregnancy.

One Administration proposal rejected by Congress would have given the Secretary of Health, Education and Welfare authority to require physicians to report directly to him on their clinical tests with new drugs.

The new law empowers the FDA to require "substantial evidence" of the efficacy, as well as safety, of new drugs before licensing them for marketing. The AMA had warned Congress that this might lead to a test of relative efficacy which could result in potentially-helpful drugs being barred from sale. The AMA contended that the old FDA requirement that a drug live up to its label claims was a sufficient test of effectiveness.

The Pharmaceutical Manufacturers Association also warned that drug research might slow down as a result of the new law.

"Some provisions of the new law may not be helpful to the public," the PMA said. "In fact, unless there is the wisest administration of the law harm can be done. For example, medical research may slow down and the costs of medications may increase."

Physicians will be required to get the consent of the patient, or a close relative, for treatment with experimental drugs except in instances where the physician feels that it would not be feasible or would be contrary to his professional judgment. Consent already is a part of the code of ethics of the American Medical Association.

Some other major provisions of the new law:—

—Authorize the FDA to swiftly suspend any drug which it suspects is dangerous.

—Require that the generic name of a drug be printed on the label in type half as large as that for the trade name.

—Extends the time during which FDA may review a new drug application before it must be approved or disapproved.

—Authorizes the HEW Secretary to establish generic names for new drugs.

—Authorizes the HEW Secretary to prevent testing of drugs on humans if he determines there has not been sufficient preclinical testing.

—Require batch certification of all antibiotics.

* * * *

Congress passed a bill authorizing a $36 million three-year program for federal aid for intensive vaccination programs against polio, diphtheria, whooping cough and tetanus.

The vaccination campaigns are to be aimed primarily at children less than five years old. The U. S. Surgeon General was given broad authority in deciding the amount and terms of federal grants under the program.

Grants will be made to states or, when approved

by state officials, to cities or other local governmental units.

Also on the immunization front, a Special Advisory Committee twice recommended to the Public Health Service that Type III oral polio vaccinations be continued for pre-school and school age children but not for adults for the time being.

The Public Health Service accepted the recommendation and urged that communities proceed with planned mass vaccination campaigns using Type III for children. But some communities decided to hold up their mass immunization programs at least temporarily or to suspend Type III doses for children, as well as adults.

The Advisory Committee first made its oral polio vaccine recommendation at an emergency meeting on September 15. The meeting was called after Canada suspended use of oral polio vaccine. The Health Ministry action in Canada, where all three types of the oral vaccine had been given in one dose, was prompted by the occurrence of a few cases of Type III polio. The three types of vaccine are given in separate doses in this country.

There also were at that time a few Type III cases reported in this country among adults who had taken the oral vaccine.

After an Oct. 2 meeting, Dr. Luther L. Terry, Surgeon General of the PHS, said:

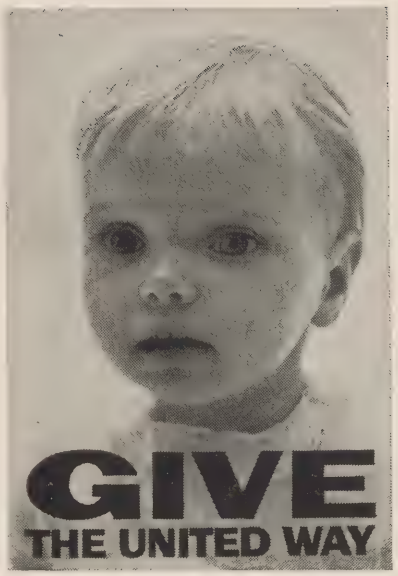
"The recommendation that Type III be confined to children has raised the question of spread from vaccinated children to adults, especially family members. The evidence does not indicate a hazard to adults exposed in this way."

"The level of this risk can only be approximated but clearly is within range of less than one case per million doses. Since the (Type III) cases have been concentrated among adults the risk to this group is greater whereas the risk to children is exceedingly slight or practically nonexistent."

* * * *

President Kennedy signed into law H.R. 10 permitting physicians and other self-employed persons to take a federal income tax deduction for private pension plans.

Kennedy signed the legislation less than six hours before the midnight October 10 deadline that he had to act on the measure. If he had not signed it by then, it would have become law without his signature. It appeared certain that a presidential veto would have been overridden.



Physicians represent less than three percent of the self-employed who could benefit under the new law.

Enactment of the legislation into law climaxed a 12-year battle in Congress. The House passed it twice, in 1958 and 1959, but it died each time in the Senate with adjournment.

This year the House passed it with a 361-0 vote. The Senate vote was 70 to 8.

The new law authorizes a self-employed individual, such as a physician, to contribute up to 10% of his earned income or $2,500, whichever is less, toward a retirement plan, provided he includes all of his employees with three or more years of service under the plan. A tax deduction of half of the contribution to the self-employed person's retirement plan would be allowed.

The contributions made on behalf of employes would be fully tax deductible.

The measure prohibits drawing on the retirement funds without penalty before age 59½, except in case of disability or death.

Death

DR. J. W. KITCHIN

Dr. Jesse Walton Kitchin of Liberty, died September 8 at Veterans Hospital, Oteen, N. C., after several years illness. He was 53.

Born in Horseshoe, N. C., a son of the late Julius Henry and Dora Galloway Kitchin, he graduated from Mars Hill College (junior) and the University of North Carolina. He received his medical degree from Jefferson Medical College, Philadelphia, and interned at the Episcopal hospital, Philadelphia, and later was superintendent of Dr. Peek's Hospital, Six Mile.

Public Relations

NEW PHASES IN PUBLIC RELATIONS PROGRAM

"Paging Freedom:"

A one-half hour program on "Medicine In South Carolina Today" was recently completed and taped for television at WUSN, Channel 2, Charleston. The film was shown on the Charleston station on Friday, September 28 in prime time at 10:30 p. m. A small display advertisement on the television page of the local newspapers publicized the production.

While the show was not heavily political, comments from local viewers were good. One viewer said: "I kept waiting for the doctors' hard sell and I was pleased when they left it up to my own intelligence to see the point . . . that we are better off without government intervention in medical care."

The film is now being edited for release to other stations in the state. Local county medical societies will be advised of show dates in their areas.

A vote of thanks goes to Mr. Hugh Lane, Citizens and Southern National Bank, who underwrote the expense of the film, and to Channel 2 who donated the time for the show, cameramen and technical advisors. Through these cooperative efforts the film was completed at minimum cost to the state Association.

SUGGESTIONS FROM ILLINOIS

The Illinois State Medical Society has for many years carried out an ambitious and successful public relations program. Parts of this program, suitable for adaptation elsewhere, are now under investigation for use in South Carolina. These segments are:

1. "Safeguard your health radio messages"—five one-minute radio spot announcements on health topics featuring actor Burgess Meredith. A tag at the end of each recording identifies the state association. Subjects are "Modern Preventive Medicine and the Family Physician," "Protective Immunization," "Mental and Physical Fitness," and "The Need for a Family Doctor."

2. "Careers In Medicine"—one of five one-minute television commercials featuring actor Burgess Meredith. The television series also covers the topics used on the radio series.

NOTE: The Illinois State Medical Society estimates that $150,000.00 in commercial time has been devoted to these projects by radio and television stations without charge to the society. As soon as these recordings and television films are received, county societies will be advised that these are available for use in their areas.

3. Small portable displays for bank lobbies, airport and train station lobbies, store windows, etc. are now under production by the Illinois society. These illuminated displays have five translucent plastic inserts, each about three feet long, making the display adaptable to five different subjects. The single unit cost is $400.00. However, The Illinois Society advises us that the unit cost will drop to less than $65.00 if as many as 100 orders are received. If your society would like to have more details on the displays,

Please write:

Public Relations Office

Box 275

Charleston, S. C.

SPEAKERS' BUREAUS:

We are still eager for more news of activity from local speakers' bureaus. Several areas have reported renewed activity this fall with requests coming from church groups and women's clubs. (To paraphrase a national magazine "Never underestimate the power of a woman!)" We would like to emphasize the importance of speeches and other attendant public relations activities in November and December. President Kennedy has already made it quite clear that he intends to come out more strongly than ever for government-in-medicine in 1963.

South Carolina Medical Association
PUBLIC RELATIONS COMMITTEE
P. O. Box 275, Charleston, S. C.

Please send the following:

SPEECHES

#1 #5
#2 #6
#3 #7
#4 #8

SPEAKERS BUREAU KITS
(Quantity)

BASIC NEWS RELEASES
(Quantity)

PAMPHLETS (Quantity)

- ☐ America—Beware of the Welfare State
- ☐ Socialized Medicine and You
- ☐ A Case Against Socialized Medicine
- ☐ The Cost of Medical Care
- ☐ I Quit Socialized Medicine
- ☐ Health Care for the Aged
- ☐ A Family Doctor's Fight
- ☐ Medical Aid for Aged
- ☐ Helping Those Who Need Help
- ☐ What Price Medical Care of the Aged?

NAME_____

ADDRESS_____

_____

Key to speeches:
1—Government-in Medicine versus Kerr-Mills
2—Food Faddism
3—Hospital Costs
4—Hidden Hazards (household poisons)
5—Care of American Businessman
6—Mental Health
7—Medicine as a Career
8—Seven Ways to Cut Medical Expenses

Organized Home Care Programs

JOHN M. PRESTON, M. D.
Columbia, S. C.

Statistics are "human beings with the tears wiped off," quotes Dr. Cecil Sheps in discussing **Progress and Potential of Home Care Programs.** It behooves us, in trying to plan such programs, to remember that we are planning for people and with people, rather than just writing up a pretty program on paper. In the same vein Mrs. Frank M. Barrie related how one of her pupils constructed a beautiful plan which included in detail everything the books say should be there, only to be disappointed by her comment, "Who's going to put it into effect?"

With more and more people over 65 in our population each year and more people each year under 20 the problem of the dependent segments of our population becomes progressively more acute. This article is not concerned with the under 20 group because each family usually manages to cope with its own situation more-or-less satisfactorily, either through its own efforts or with the ADC (Aid to Dependent Children) program helping out. The aging and the chronically ill, however, present a different picture. These people can be expected to become more and more dependent instead of more and more independent as the years go by. Modern living and modern housing are not geared to the three generation family as were the customs that prevailed some thirty to fifty years ago.

Now let's turn our attention to the problem of organized home care as we see it.

THE NEW ORGANIZED HOME CARE

Mothers and doctors have been providing home care for many many years, but both types are changing rapidly these days. More mothers are now employed full-time in the business world, leaving the home care to grandmothers, day-nurseries, baby-sitters and even hired maids and attendants. Physicians rarely make house calls, since so much of their diagnostic equipment is rather stationary in their offices. The term "Home Care," is therefore beginning to take on an entirely different meaning from what it formerly had. The connotation "Organized" is fast attaching itself to the original term.

Organized home care offers its greatest advantage to the person (and his family) with chronic disease or long term disability. These people are usually though not always in the older age-group where recovery from many conditions is slowed down if indeed it is possible at all. They may have had an acute condition requiring attention in a general hospital, but have improved enough to be dissatisfied with hospital routines and seriously concerned with the matter of hospital expense. Even the indigent and medically indigent fall into this category though it is the taxpayer who does the worrying about the mounting costs of accumulating hospital days. People, particularly elderly people, frequently get to the place where they are too well to remain in the hospital, but too sick to be independent. It is this group which gives us much concern in planning programs of organized home care.

The situation just described is not intended to picture home care programs as a substitute for hospitalization, but rather as a supplement to it. No amount of substitute or supplementary planning can solve the problem, however, unless the necessary professional services can be made available in the home. The key to organized home care is the advantage it offers to the patient and his family in the provision of long-term care in his own home where he is best adjusted.

TYPES OF CARE

Programs of home care are of two major types and most communities have most of the ingredients necessary to start one or the other. They are (1) the hospital-based plan and (2) the community based plan. In the former the hospital has an extra-mural arm that reaches out into the community to extend care to the patient with long-term illness. In the latter the community takes an existing service such as the Visiting Nurses Association and builds on it a program of home care for suitable cases. Many authorities consider the hospital-based plan preferable and they may be right; at least there are more of that type than those community based.

Organized home care plans include much more than simply home nursing visits. The three basic components are: (1) comprehensive care, (2) coordinated service and (3) community responsibility. Medical leadership of a strong, aggressive and understanding type is basic to the success of any such plan. The traditional doctor-patient relation must never be disturbed. A physician follows his private case through this plan, assuming complete responsibility for it, but has the resources of the community cooperation, hospitalization and nursing services of education, demonstraton and observation to assist him. If the case is indigent rather than private he still maintains the same relationship but is paid by public funds. For this fee he is expected to make certain reports, attend certain case conferences in regard to the patient and utilize the available consultative service when it is indicated. One important aspect of organized home care programs is the assured availability of hospitalization when such is necessary.

Organized home care plans are not to be

thought of as financial short-cuts, hospital bed-savers, or make-shift care, though they may actually furnish some elements of all of these. They are not "doofer" arrangements — something that will have to "do for" the present until we can get something better. They are proving to be the best type of medical service that can be rendered to a certan segment of our population. In the Beth Israel Hospital plan (typical of many others) which has been operating for about seven years now, it has been found that the patients suitable for home care are happier and progress as well, if not better, surrounded by loving and affectionate care, than patients constantly hospitalized. They respond to rehabilitative programs better and return more quickly to their normal functional capacity. A higher standard of total medical care is thus afforded them, and more effective use is made of expensive community facilities.

Programs of organized home care have been in operation now for about fifteen years and some of them have proven very effective. Still, we have only about 3,000 to 5,000 people covered by such services. In view of such successful demonstrations in the face of an admitted need we have to ask ourselves "'Why haven't we more of these plans?"

There are many factors involved in the answer to that question and we shall attempt to point out and discuss briefly a few of them. In general they can be condensed to the basic "'fear of the unknown." People are somewhat loath to cast aside the old and try the new. It is difficult to change the "status quo." In this century of nuclear fission, orbital flights and a thousand other "firsts" why should we not change our patterns of medical practice more readily? Perhaps the answer lies in the attitude of the individual. Each one of us crossed our fingers if we didn't actually say a little prayer for Allen Sheppard and John Glenn on their space flights, but we would not have gone in the capsule with them. "Home care programs are all right for some people but local plans might even affect our own incomes!!"

THE RELUCTANT PUBLIC

The public is a little reluctant to accept the new system, and how can we blame them? For a good may years, now, we have been building up the idea of the hospital as the safest place for the sick person. We have almost made it the sacred temple of the health of the community, so that the idea of the return to the home sounds almost like pure heresy. The day has gone when the family doctor came into a home with his little black bag, sat by the patient's bed and looked at his tongue, reached into the bag for his total investment in diagnostic equipment (thermometer and stethoscope), made his diagnosis on symptoms and signs and poured out a handful of pills from a bottle in that same bag and didn't even take a bottle of urine back to his office for testing. Today you call your doctor and he says, "Meet me at the hospital." And we meet him there for elaborate laboratory studies because that is the type of medical practice we want, accept and demand. No wonder there is surprise and even reluctance to think better care can be found at home.

THE DUBIOUS DOCTOR

The doctors are reluctant to accept the new system. They have invested time, money, blood, sweat and tears in hospital-centered medical schools, internships and residencies. Hospital diagnosis and treatment is all they know. Their offices are filled with diagnostic gadgets they can't put in their cars, much less in little black bags. They know that one "peek" into the body with x-ray or one of the various "—scopes" is worth a thousand thumpings or proddings. They know that when their diagnosis is made and treatment selected the hospital will see to its completion and a grateful patient will go home to call him again when the next health crisis arises. But what of the patient sent home on some kind of home care program? "Who are those nurses that will be visiting in the home? Why do I have to report to a bunch of other doctors? I don't have time to fill out all those forms. Who will the patient call next time? Who's going to pay my fee? If its the Federal Government, they'll soon be telling me how to treat my own patients!! I don't want any part of it — except, of course, the cash!" No, the doctor's training and attitude needs considerable renovation before he will readily accept the new program.

THE HESITANT HOSPITAL

The hospitals are reluctant to accept the new system. Every hospital is crying "poor-mouth". Practically every hospital is over-crowded and under-staffed and all are under-financed. They have been built to take care of the sick and they grudgingly expect to lose money doing it so they say, "If we've got to take care of the chronically ill, bring them to us where we are set up for the business with central kitchen, central heating, linen service, food purchasing, etc. We can do the job for the community cheaper with the facilities we already have, but don't ask us to go out into the highways and hedges." The sidewalk around the hospital is almost like the moat around an ancient castle. There is a sense of security inside the hospital — security for the patient and the doctor — and a sense of autonomy for the hospital administration.

The insurance companies are reluctant to finance the new programs. Blue Cross and Blue Shield operate on a "cost" basis. They have little

or no reserves for experimenting with new coverages. Any large losses would necessitate an increase in current rates beyond what the public will stand. Commercial companies who operate for profit are handling stockholders' money and can't afford to lose it, or the stockholders will seek new investments. Neither type of company has any uniform cost data nor any specific idea of the scope of coverage necessary to enable their actuaries to compute rates of premiums and benefits. The public hasn't the vaguest idea how much coverage it wants or needs nor what it is willing to pay for it.

The appropriating bodies are reluctant to levy new taxes for the new program (except Social Security and that is the poorest way to pay for home care). Most persons are taxed just about to the limit now and would raise a mighty howl if this additional burden were saddled on them, and would vote for new legislators in the very next election. Besides, if the public is not sufficiently sold on the program to begin demanding some form of insurance coverage for it, then that public is not ready to be taxed to support it, even though it be ever so wise for them to have it.

Our leaders are reluctant to buck so much reluctance. Discussion groups in the Chicago Workshop listed such obstacles as (1) lack of leadership, (2) lack of community resources, (3) lack of communication, (4) lack of personnel, (5) lack of training facilities, (6) lack of uniform standards, (7) lack of this and lack of that, but most of this is pure rationalization. Leadership is where you find it and community resources are not far away from leadership. Finances and personnel have always been found for what the public really wants and standards and training will be developed in their turn.

MEANS OF ACCOMPLISHMENT

Thus we have traced the development of organized home care plans and have considered some of the deficiencies and difficulties in planning for them. Now we must ask ourselves what we are going to do about it.

The changing of peoples minds is a slow and arduous task — but it can be done. It just takes time. Education then, is the answer to the problem, and even in these days of swift communication and mass media the results are slow in coming. Ideas can be expressed in words; words can be transformed into electromagnetic waves which can be hurled around the world in a fraction of a second and reconverted into words by receiving sets. The words can be received in some listener's brain and converted to ideas again but the acceptance of those ideas and their translation into voluntary action is quite another matter. No reliable method of speeding-up that part of the process has yet been found.

Since we have no magic formula for rapidly changing people's minds there is but one thing left to do — use the methods we do have. That is being done now. Almost every medical and social journal one picks up, has one or more articles on home care in it. One of the best is a less-than-one-page editorial that appeared in the **Journal of the American Medical Association** for April 12, 1958. The quoting of one sentence will have to suffice here, though the whole page is well worth it. "In the home it may be easier to forget one's illness; subconsciously at least, death seems farther away when one is at home."

There is a great deal of lip-service given to the virtues of home care programs, but the persons who have deep convictions on it are relatively few. The American Medical Association has accepted and endorsed the validity and usefulness of organized home care programs but the individual practicing physician is not yet convinced. The whole idea is so foreign to his traditional pattern of physician-patient relationship that it represents the new and unknown to him and he is naturally skeptical. Our educational approach to him must not be on the "here's what's good for you and your patient" level but rather on the basis of "here's what looks promising — let's experiment with it and learn about it together".

Officially, the American Hospital Association has endorsed the principles of organized home care, but the individual hospital administrators are still reluctant to put them into practice.

Much the same can be said for Public Health. Officially, home care is approved and recommended, but not many Public Health administrators have adopted it into their local programs.

Everywhere we look we find a hesitancy to undertake these new programs even though a dozen or so are successfully demonstrating their advantages. Why, then, is there this general hesitancy? It is probably due to the persisting indecisiveness of the practicing physician. Nobody wants to get into trouble with the doctors. All these problems of attitude must be worked out simultaneously, with the most emphasis being put on educating the practicing physician.

Some people have said we should educate the public first and when they understand the programs they will so strongly demand it that all the professional disciplines will have to fall in line. This is dangerous ground. No medical based program can succeed without the active, strong, participating leadership of the medical profession.

It has not been very long since venipuncture was a field never invaded by other than M.D.'s and group-practice was considered a mild form of charlatanry. Both are accepted to-day as normal procedures in every-day living. A few doctors

are you ready, doctor?



...for the steadily increasing number of women who want the "Pap" smear as part of their regular checkups? By 1961, the number who had this cytologic examination had climbed to an estimated 10,000,000!

While the educational program conducted by the American Cancer Society has succeeded in alerting women to the vital importance of the "Pap" smear, it is the physician who plays the key role. This was confirmed in a recent survey of women who had had the "Pap" smear. It was revealed that 76% had it because it was recommended by a physician and 12% had it as part of a regular physical examination. Thus a total of 88% had it because of physicians' actions.

As the number of uterine cytological examinations rises, the death rate from uterine cancer declines. Many authorities estimate that most deaths from this disease could be eliminated if these examinations were routinely performed. More and more women are ready for it and are willing to budget time and money for it. Are you ready for them, doctor?

AMERICAN CANCER SOCIETY

South Carolina Division, 701-5 Old Carolina Life Bldg., Columbia, S. C.

used to decry mass typhoid immunizations by Health Departments because it deprived them of some of their summer income from treating the disease, but the welfare of the community has won over the avarice of a few. The saddlebags thrown across the doctor's horse have given way to the corner drugstore which dispenses the latest wonder drugs on the doctor's prescription.

These are but a few of the changes wrought by progress — no little part of which was accomplished by Public Health Education.

Conclusion

When we ask ourselves why we do not have more programs of organized home care we are forced to face the answer that we have not yet done our job of Public Health Education sufficiently well. Rome was not built in a day, nor are attitudes changed over night. We are making progress in teaching this new type of medical care and we can confidently look forward to the day when most communities will have organized programs of home care. Meanwhile, it is our opportunity and obligation, as Public Health Workers, to hasten the coming of that day through Public Health Education.

Book Reviews

PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE. G. E. Burch and N. P. DePasquale. C. V. Mosby Co. St. Louis, 1962. 141 Pages. $5.50.

This small monograph is concerned almost exclusively with the actual technique of measuring blood pressure by the auscultatory method. Around the explicit description of how this important but simple maneuver is carried out are wrapped chapters on the history of blood pressure recording, superficial comments on the physiology of arterial blood pressure, and on diagnostic applications of arterial blood pressure recordings. There are also chapters on sources of error in measuring arterial blood pressure, factors affecting it, and the range of normal values through life from premature babies to senescence. Attached to this full treatment of a small subject is a coda of 15½ pages of references. The book does contain some interesting nuggets of information particularly on such subjects as cuff sizes, the determination of blood pressure in infants and in the obese. However, it should be of value only to those students first becoming familiar with sphygomanometry and to those with a special interest in the subject, but the general medical reader should already be familiar with the information it contains.

C. M. Smythe, M. D.

Editors Note: By strange chance two reviews of this book were received nearly simultaneously. We therefore do the unusual thing in adding below the second review. Perhaps this is some sort of record. J. I. W.

This little monograph is a concise and accurate summary of our knowledge of clinical measurement of blood pressure. However it presents nothing new. One would like to see a little evidence pro or con on the old question of the proper diastolic level as determined by auscultation and perhaps a little more on the mechanism of Korotkoff sounds. Some (e.g. Roth, Kvale) would take exception to the authors' advocacy of urinary catechol amine levels over the provocative tests in diagnosis of pheochromocytoma.

There are a few useful reminders in this book for students which might well be summarized in two or three pages. Perhaps the two commonest errors in evaluating blood pressure are acceptance of isolated readings as being representative, and misconstruing (and hence treating) simple systolic elevations due to stress, fatigue, rigid arteries, etc. as true hypertension. These merit more emphasis in a book on measurement of blood pressure.

Dale Groom, M. D.

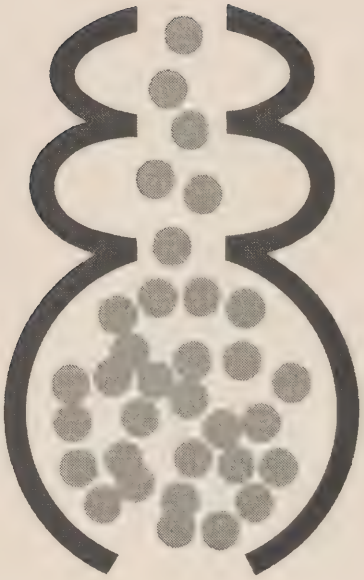
THE RELUCTANT SURGEON, A Biography of John Hunter by John Kobler (Doubleday & Company, Inc., Garden City, New York, 1962) Price: $1.45.

When this book appeared in more elaborate and durable form several years ago, it was reviewed most favorably and furnished a great deal of pleasure to many readers who found the biography interesting medically and well written in a literary way. Its new appearance in a less expensive and perhaps more handy form should be a valuable contribution to many potential readers both in and out of the profession. It has lost nothing of its attraction by the passage of years, and can be readily recommended to those who would like "to reclaim the scientist from the archives and the man from the shadows."

J.I.W.

POSTPARTUM PSYCHIATRIC PROBLEMS. James Alexander Hamilton, Ph. D., M. D. The C. V. Mosby Co., St. Louis, 1962. $6.85.

Although the reviewer was brought up to feel that postpartum psychoses were related to pregnancy only in being the result of a non-specific stress, this 150 page monograph which takes the opposite view is worth reading. While much of the text concerns



LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)

ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

psychiatric technicalities of nomenclature and therapy, an obstetrician can profit from the study of a serious complication that he rarely sees.

Of four thousand cases requiring hospitalization in mental institutions each year, 20% are never returned to a useful life. The author stresses the early symptoms and the usual lack of their recognition by the obstetrician.

Entirely new to the reviewer was the existence in many cases of a marked hypothyroidism as indicated by a low PBI level and a dramatic response to triidothyronine and thyroid in some cases. Of very practical interest is the application of this finding to the so-called "obstetrical blues" and postpartum depression not severe enough to require hospitalization.

The chapter on endocrine relationships contains much food for thought but little actual meat.

Being only a pragmatic materialistic accoucheur, the reviewer is not qualified to comment on the several chapters dealing with psychiatric dialectic:

"Find out the cause of this effect,
Or rather say, the cause of this defect,
For this effect defective comes by cause."

James M. Wilson, M. D.

THALASSEMIA, A Survey of Some Aspects. Robin M. Bannerman, M. D. Grune & Stratton, New York, 1962. $6.50.

This Modern Medical Monograph is far more broad in scope than its title would suggest, covering many aspects of hematology of importance in the blood dyscrasias.

The historical aspects, genetics and clinical features of thalassemia are well covered and add much to the understanding of the mode of inheritance of not only this "inborn error of metabolism" but other types of inheritable blood disorders. The chapter on hemoglobin metabolism is especially pertinent, describing much of the recent work on variations of amino acid structure of hemoglobin in the various hemoglobinopathies, and the current ideas of classification and the inter-relationships of hemoglobin A, F, S, etc.

Hemoglobin catabolism is well reviewed and the interesting concept of "ineffective erythropoesis" is explained. This gives a much clearer understanding of not only thalassemia but many more common forms of anemia such as that due to iron deficiency. Erythrokinetic studies are described as well as elucidation of the significance of free erythroyate protoporphyrin, free coproporphyrin, stercobilin, etc., in the studies of different types of anemia.

This monograph is an excellent review of thalassemia and related disorders and can be highly recommended for the physician interested in hematology or genetics. It would be too detailed to be of interest to the general practitioner or student.

Charlton deSaussure, M. D.

THE CONSUMERS UNION REPORT ON FAMILY PLANNING. By Allen F. Guttmacher, M. D. and the Editors of Consumer Report. Consumers Union of the United States, Inc. Mount Vernon, New York, 1962. Price $1.75.

This is a practical handbook which gives comparisons of various methods of contraception with comment as to effectiveness, cost, convenience, and safety, etc. It also includes brand-name-ratings of contraceptive materials. It is intended to be a guide for the childless and includes a discussion of infertility.

This appears to be a sound booklet which should serve a very useful purpose for those interested in family planning.

J. I. W.

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN, by C. Lee Buxton, M. D. W. B. Saunders Co. 1962 $4.75.

This small book of 116 pages consists of an excellent introduction followed by 13 chapters. The introduction gives a very good synopsis of the subsequent material, obtained by the author in extensive travels in Europe to gather information from the various clinics with their dissimilar methods of approaching the problem of pain in childbirth.

The book is comprehensive in its coverage of the methods in use without going into specific details of the programs. It covers the Pavlovian Conditioned Reflex Methods, Read and Heardman's Natural Childbirth, Autogene Training and hypnosis. There is also an excellent chapter on "pain."

The author does not answer the question "which is the ideal method?" However, from reading about the various techniques one draws the impression, and rightfully so, that any method which tends to bring about a closer relationship between patient and physician, thus increasing rapport, results in benefit to the patient.

Willard C. Hearin, Jr., M. D.

TOMORROW'S MIRACLE. Frank G. Slaughter. Doubleday & Co., Inc. Garden City, N. Y. $3.95.

Dr. Slaughter brings a new type of physician into this one of his many novels which invoke the medical picture. The hero of the book is a member of a sharecropper family who manages to obtain his medical education at what seems obviously to be the John's Hopkins Medical School of nearly 40 years ago. Intertwined with his medical conviction is unchecked willingness to serve as an evangelist and faith healer, in which capacity he does his best to separate the faith healings from what might be true cures. Walking a fine tightrope, the hero manages to wind up as a dedicated medical missionary in Guiana.

There is enough of the medical picture for those non-medical people who delight in such things, and to satisfy the technical requirements of the physician

reader. A love affair which has its difficulties carries on through the book and ends in a situation in which it would appear that all the good people will live happily thereafter.

J.I.W.

SELF HYPNOSIS. Lawrence Sparks. Grune and Stratton, Inc., New York. 1962. $5.75.

The idea of self-hypnosis is simply an extension of ordinary hypnosis with the exception that practitioner and subject are one and the same. Hypnosis is based on suggestability and it is quite understandable that suggestability might work well on oneself as well as on someone else. In his book, Mr. Sparks discusses self-hypnosis as a conditioned response technique. He sees most of the problems and symptoms which manifest themselves as a conditioned response. This technique involves the development of opposite and opposing self-conditioned responses. Mr. Sparks described a general theory and his techniques for use in development of the art of relaxation, concentration, and discipline of the voluntary mind. It pointed out that many of us use self-hypnosis in various forms. Reference is made to the individual who is able to wake himself up on time without an alarm clock and of individuals who can "concentrate" in spite of distractions. These are described as self-induced hypnotic states.

The American Psychiatric Association has issued a statement defining its feelings about hypnosis. "Hypnosis is appropriately and properly used in the course of therapy only when its employment serves therapeutic goals without posing undue risks to the patient." It is in this particular area that most psychiatrists find ammunition for their opposition to hypnosis. The rather naive idea that removal of a symptom represents a "cure" is a rather dangerous supposition espoused by many so-called "practitioners" of hypnosis. When one views a symptom as a compromise solution of an emotional conflict, it becomes quite evident that the removal of the so-called "symptom" is in essence a removal of the "solution."

There are areas in this book which are of value and conclusions which are generally acceptable, but one finds the same error in Mr. Sparks' thinking so common to the "practitioners" of hypnosis. Mr. Sparks discusses in his 9th Chapter the improvement of one's ability to recall certain events. In this area any sort of self-hypnosis might be immune to criticism. In his next chapter, he rather bravely proceeds to discuss the treatment of obesity by self-hypnosis, followed by a chapter on alleviation of pain, and then the removal of anxiety. This is then followed by discussions of sexual disorders such as impotence and frigidity. It is rather unfair to any method or technique to make broad, sweeping statements of condemnation. Hypnosis has been and is still being used by skilled psychiatrists with success. None the less, when it is used as a therapeutic tool in the treatment of some emotional or physical disorder by a lay person, it amounts to practicing medicine without a license.

George H. Orvin, M. D.

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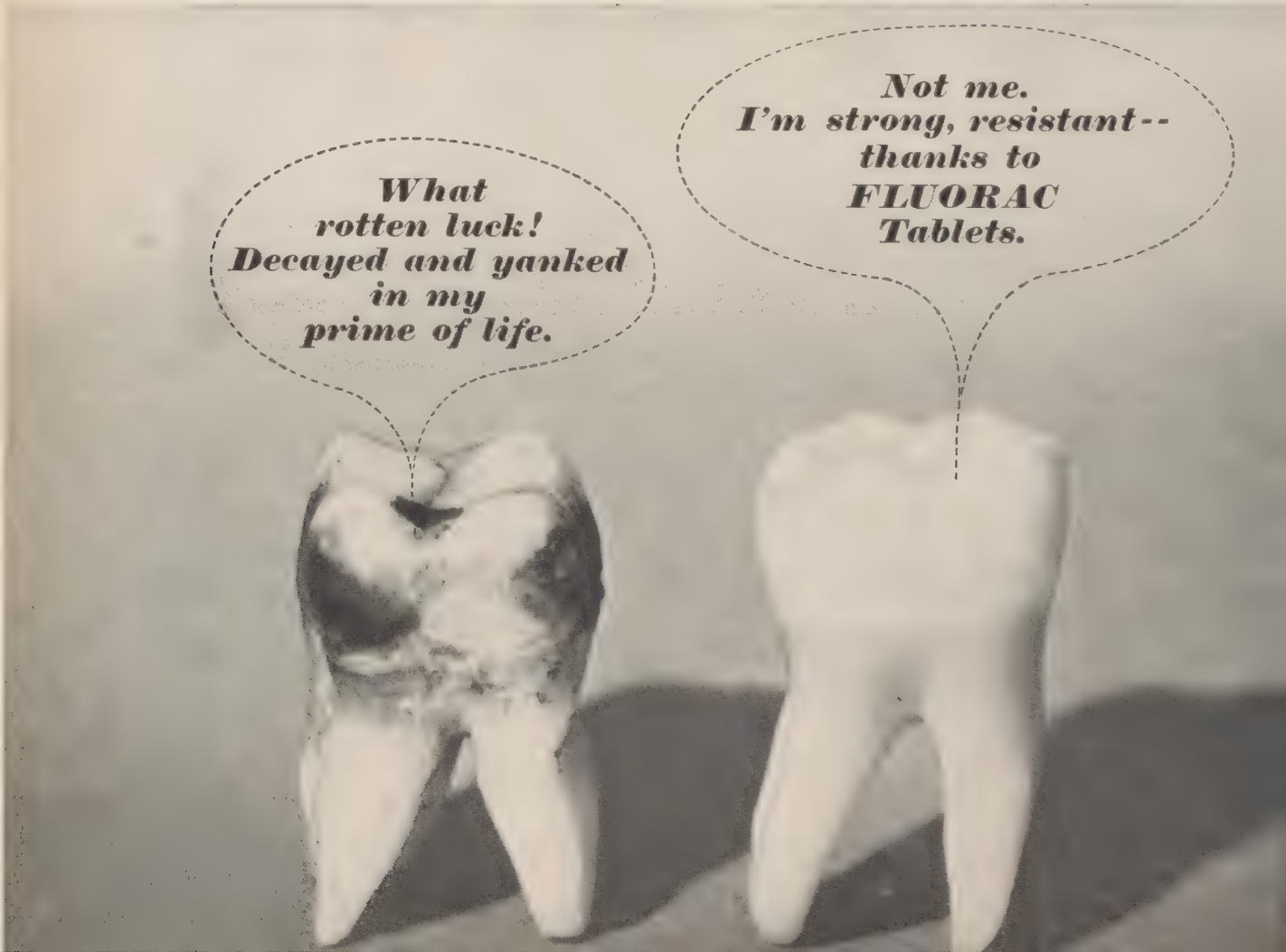
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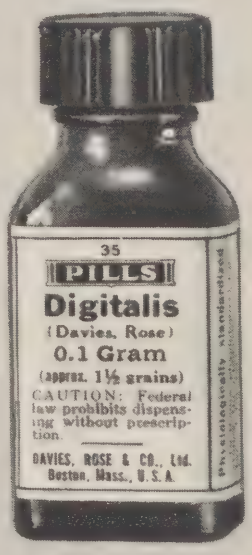
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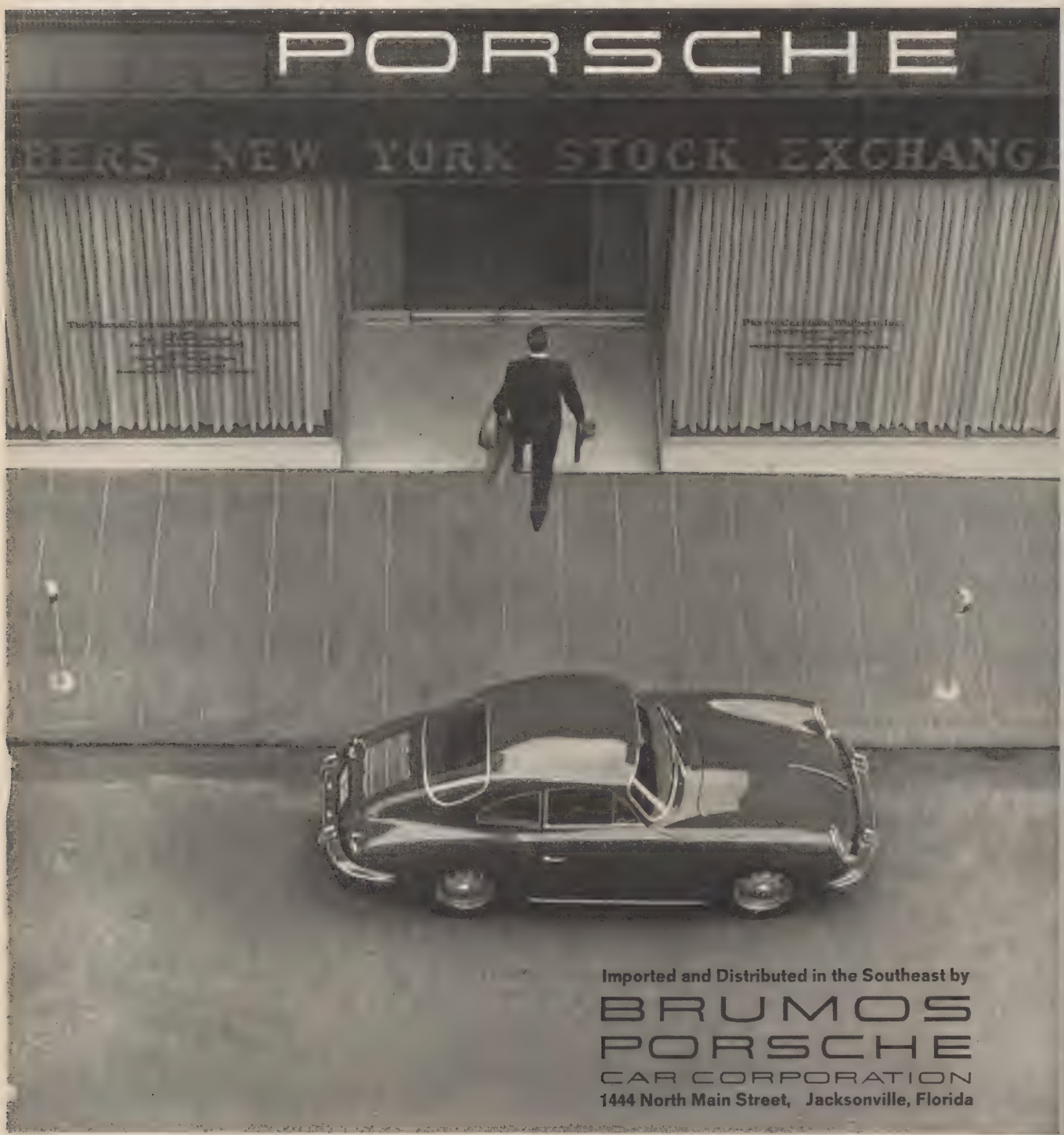
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Pentylenetetrazol.....200 mg.
Nicotinic Acid.....100 mg.

HART | Division of A. J. Parker Co. LABORATORIES Winston-Salem, North Carolina

NICOZOL®

Logical support for the atherosclerosis diet

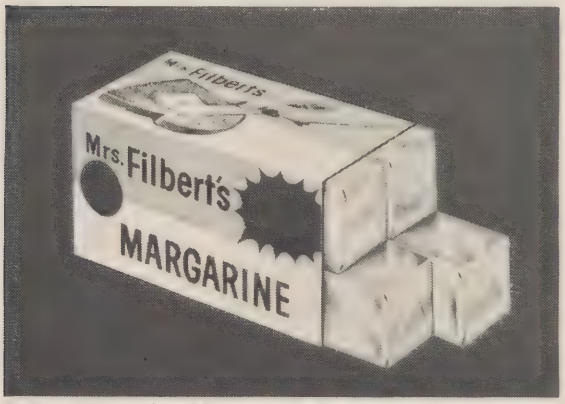
A recent report* in the *JAMA* on atherosclerosis states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, it is in your professional interest to know about the fatty acid composition of the margarines from Mrs. Filbert's.

Each of Mrs. Filbert's Margarines is over 80% unsaturated and offers unique properties useful in the control of serum lipids by dietary means.

Moreover, when you recommend any one of Mrs. Filbert's Margarines, your patient is assured of unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181: 411-423 (August 4, 1962).



Mrs. Filbert's Margarine is a popular, conventional-type margarine with no premium price. It is made from the finest domestic vegetable oils, which are partially hydrogenated for texture, but remain over 80% unsaturated. It has a ratio of polyunsaturates to saturates in excess of 1 to 1. Of the total fatty-acid content, 7% is cis-cis linoleic acid.



Mrs. Filbert's Whipped Margarine contains the same number of calories per pound as ordinary margarine, but contains 30% *fewer calories per pat* because it is whipped. When spread normally, it provides satisfaction with a reduction in fat calories. And its ratio of polyunsaturates to saturates exceeds 1 to 1. Of the total fatty-acid content, 7% is cis-cis linoleic acid.

If you would like information about Mrs. Filbert's family of margarines—including detailed listings of their component characteristics—please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND



The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruits or juices.

© Florida Citrus Commission, Lakeland, Florida



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Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 11th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 55,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife for whom a special program is planned.

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Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
The Marott Hotel

ANAHEIM, CALIFORNIA
Sunday, November 11, 1962
The Disneyland Hotel

KNOXVILLE, TENNESSEE
Thursday, November 15, 1962
Hotel Andrew Johnson

PHOENIX, ARIZONA
November 18, 1962
Westward Ho Hotel

NEW CITY, NEW YORK
Wednesday, November 28, 1962
Dellwood Country Club

LOS ANGELES, CALIFORNIA
November 29, 1962
Ambassador Hotel

GRAND RAPIDS, MICHIGAN
Saturday, December 1, 1962
Pantlind Hotel

NORFOLK, VIRGINIA
December 6, 1962
Golden Triangle Motor Hotel

DENVER, COLORADO
Sunday, January 13, 1963
The Cosmopolitan Hotel

FORT SMITH, ARKANSAS
Tuesday, January 15, 1963
The Holiday Inn

PORTLAND, OREGON
Thursday, January 31, 1963
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 23, 1963
The Anchorage Westward Hotel

DETROIT, MICHIGAN
Wednesday, February 27, 1963
The Sheraton-Cadillac Hotel

WILMINGTON, DELAWARE
Saturday, March 9, 1963
Delaware Academy of Medicine

HUNTSVILLE, ALABAMA
Thursday, March 14, 1963
The Russel Erskine Hotel

FARGO, NORTH DAKOTA
Saturday, March 16, 1963
The Frederick Martin Hotel
(Moorhead, Minn.)

BELLINGHAM, WASHINGTON
Saturday, March 23, 1963
The Hotel Leopold

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America's fastest growing city plays host to the nation's biggest winter medical session—the AMA Clinical Meeting. For the first time in eleven years, the AMA will present in Los Angeles a complete, comprehensive four-day program featuring the newest advances in medicine.

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See JAMA October 27 for complete scientific program, for physician registration and hotel reservation forms.

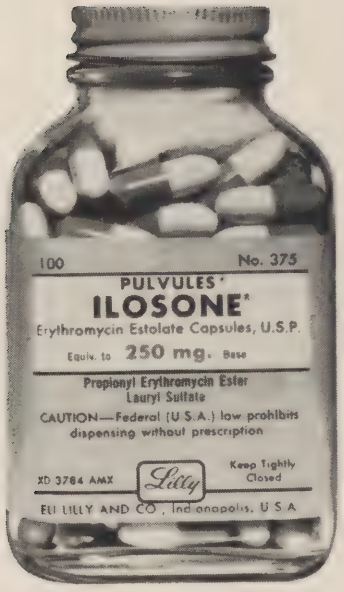
SPECIAL PROGRAM HIGHLIGHTS
SUNDAY THROUGH WEDNESDAY

Air pollution and pulmonary disease
Viral hepatitis
Clinical nuclear medicine
Depression and suicide
Surgery—general, dermatologic, thoracic and neurologic
Cancer—etiology, pathogenesis, and chemotherapy
Orthopedics
Children's growth disturbances
Cineradiography
Anesthesiology
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sign of infection?

symbol of therapy!

Ilosone® is better absorbed—It provides high, long-lasting levels of antibacterial activity—two to four times those of other erythromycin preparations—even on a full stomach. **Ilosone is bactericidal**—It provides bactericidal action against streptococci, pneumococci, and some strains of staphylococci. **Ilosone activity is concentrated**—It exerts its greatest activity against the gram-positive organisms—the offending pathogens in most common bacterial infections of the respiratory tract and soft tissues.

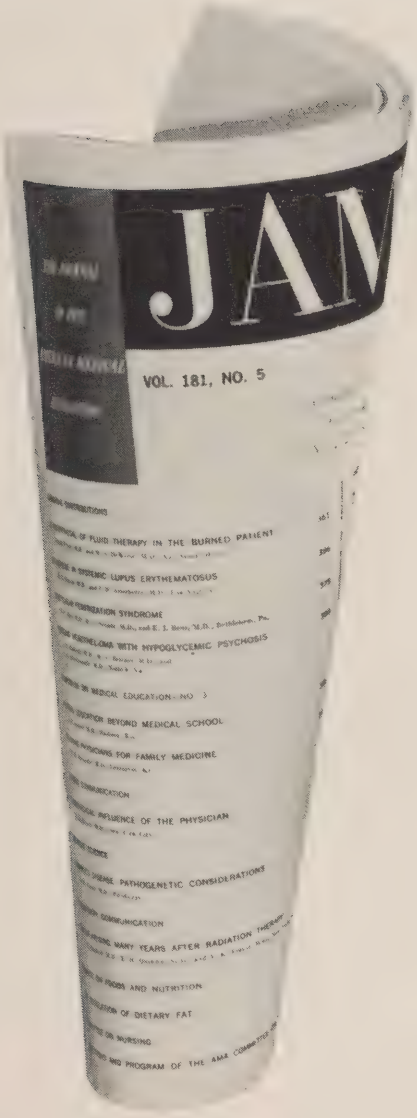
The usual dosage for infants and for children under twenty-five pounds is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. For adults and for children over fifty pounds, the usual dosage is 250 mg. every six hours. In more severe or deep-seated infections, these dosages may be doubled. Ilosone is available in three convenient forms: Pulvules®—125 and 250 mg.*; Oral Suspension—125 mg.* per 5-cc. teaspoonful; and Drops—5 mg.* per drop, with dropper calibrated at 25 and 50 mg.

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Eli Lilly and Company, Indianapolis 6, Indiana. Ilosone® (erythromycin estolate, Lilly) *Base equivalent

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Ilosone works to speed recovery





Because you are aware of the AMA statement on fat in the diet...

"Increasing the ratio of poly-unsaturated fat to saturated fat in the diet is the preferred method for treating the 'usual' hypercholesteremia."

From the Aug. 4, 1962 issue of The Journal of the American Medical Association.

Of all leading salad and cooking oils Safflower Oil has the highest ratio of poly-unsaturated fat to saturated fat. Safflower Oil is higher in recommended poly-unsaturates—lower in saturated fat than any other readily available oil or shortening.

When an adjustment in dietary ratio of saturated fat is indicated, Saff-o-life

you should be aware of this new, poly-unsaturated oil for cooking

Safflower Oil makes the substitution easy, appetizing, inexpensive.

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to: Professional Services Director, General Mills, Inc., Department 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.

RATIO OF LINOLEATES* TO SATURATES *poly-unsaturated fats

SAFFLOWER OIL	9.0 to 1.0
CORN OIL	5.3 to 1.0
SOYBEAN OIL	3.5 to 1.0
COTTONSEED OIL	2.0 to 1.0
PEANUT OIL	1.6 to 1.0

A product of General Mills—Your assurance of quality and purity.



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The design of the Cambridge Defibrillator emphasizes reliability, convenience and speed of operation—since time and reliability are of utmost importance. Based on latest medical findings, the Cambridge Defibrillator represents an important development in cardiac resuscitation. Fully portable, it offers many new operational features.

The Cambridge Defibrillator is operated by *one* person. It *eliminates* voltage estimating by providing two fixed settings—one for an adult, the other for a child. An *automatic* timing device assures the correct duration of the shock. A thumb button positioned on the right electrode—where it can be used most naturally and effectively—assures absolute control.

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Examine and test the Cambridge Defibrillator, Doctor, and see how simple, uncomplicated and uncluttered an effective Defibrillator can be . . . and inexpensive, too! A demonstration of this new, complete instrument will be gladly given—just phone your nearest representative.



EASILY PORTABLE—SELF CONTAINED UNIT. Weighs only 26 lbs. Even the smallest nurse can carry it. All components are contained within a sturdy, compact aluminum case—no accessories to forget or lose.

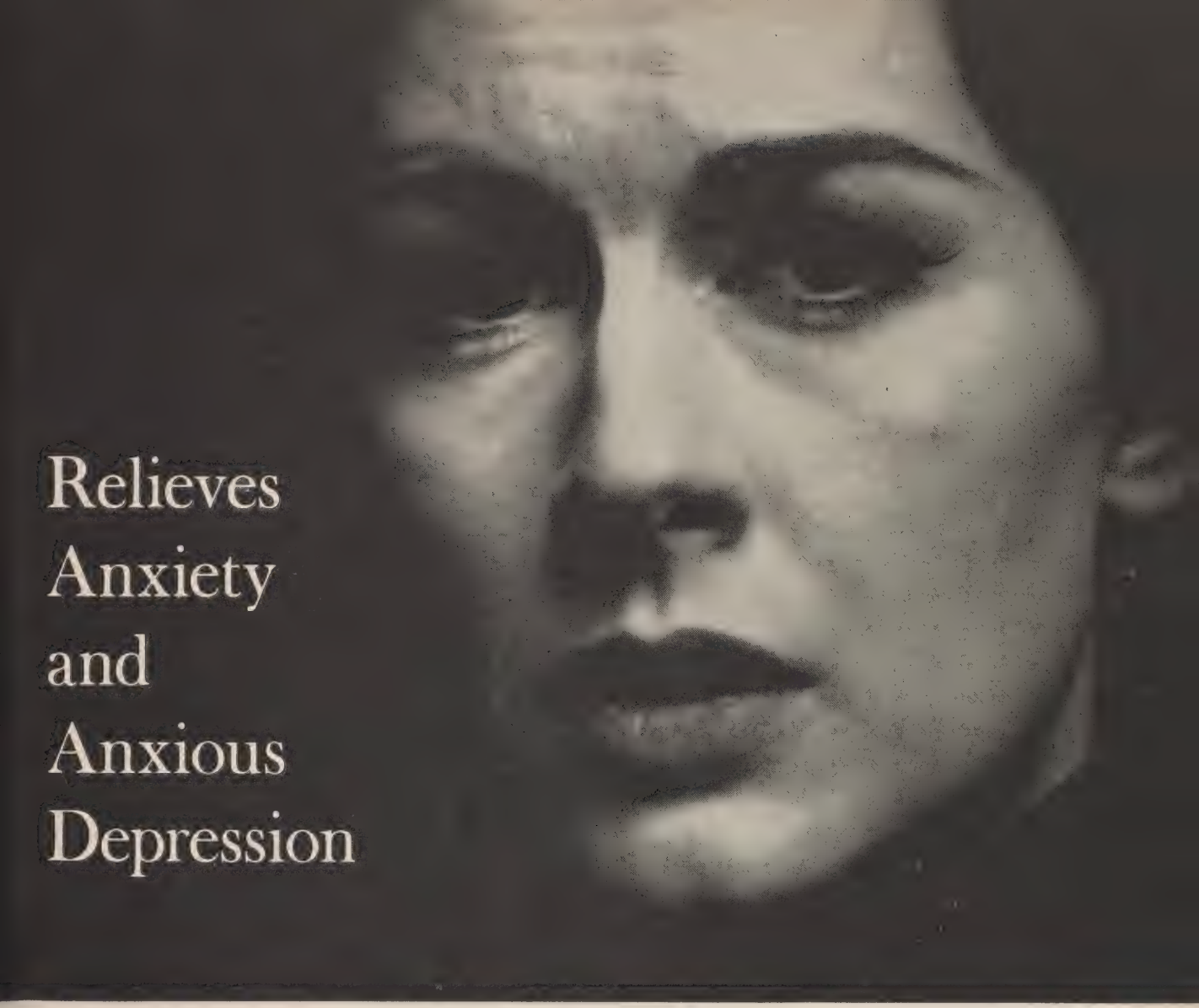
BUILT-IN THUMB CONTROL. Right under the doctor's thumb on the electrode handle—where he can press it naturally, firmly and at the right instant.



Send for Bulletin 480

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The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom – has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

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Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® – 400 mg. *unmarked,* coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

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Clinically proven in over 750 published studies

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PROVIDES 10 - 12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

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Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate plus 50 mg. Secobarituric Acid. Medication is released over 10 to 12 hours with fewer side effects and less "hangover" than the longer acting barbiturates. As with Antora, capsules are administered only twice daily instead of the usual 8 to 12 tablets. Administer with caution in glaucoma.

REFER TO PDR

PAGE 643

Supplied: Bottles of 60 and 250. Literature and clinical samples available.

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PHARMACEUTICALS

1042 WESTSIDE DRIVE

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A variety of diet dishes to choose from. Ham 'n egg rolls, eggplant casserole, garden beans, oyster stew, gelatine and—beer!

How to help your patient stick to a low-purine diet

The acceptance of any diet depends on its appetite appeal. And this low-purine diet is unusually appetizing! Ham rolls stuffed with scrambled eggs or chilled egg salad make a delicious entree, as does a casserole of eggplant and tomato layered alternately with cottage cheese. A dash of lemon juice flavors fresh vegetables like string beans and beets. Fresh skim milk mixed with dry skim milk powder add a "creamy" taste to oyster stew. Tuna-burgers go nicely with noodles. Fruits and gelatins make excellent, easy desserts, while corn and rice flakes brighten breakfasts.



And a glass of beer can add zest to your patient's diet

104 calories,
17 mg. Sodium / 8 oz. glass
(Average of American Beers)

United States Brewers Association, Inc.

For reprints of this and 11 other diet menus, write us at 535 Fifth Avenue, N.Y. 17, N.Y.

Stelazine® will stop anxiety—but not your patient!
brand of trifluoperazine

To be truly useful in your office patients, an ataractic agent must not only relieve anxiety; it must also leave these patients sufficiently alert to engage in their normal activities.

'Stelazine' is such an agent. Its ability to relieve anxiety without producing appreciable sedation has been established in thousands of patients and documented by many published reports. Typical is the finding of Kolodny,[1] who concluded that the primary advantage of 'Stelazine' over many other tranquilizers seems to be "its ability to relieve symptoms of anxiety without undue interference with alertness."

When you wish to relieve anxiety, yet encourage the patient to engage in his normal activities, consider 'Stelazine'.

1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

For prescribing information, please see *PDR* or available literature.

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leaders in psychopharmaceutical research

SK&F



Why Sardo® is the **BATH OIL OF CHOICE** for dry, itchy skin



Why does SARDO so effectively relieve[1-5] dryness and itching in so many patients with eczematoid dermatitis, atopic dermatitis, senile pruritus, contact dermatitis, soap dermatitis, diabetic dry skin, neurodermatitis?

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HIGH QUALITY SARDO is the **original, exclusive,** high quality water-dispersible bath additive oil.*

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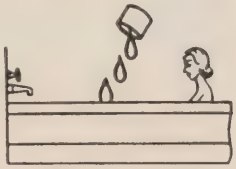
SARDO promptly disperses millions of microfine globules uniformly throughout the bath water; no unsightly oil slicks as with certain other bath additives.

SUPERIOR ADSORBABILITY SARDO covers the skin with a fine, unobtrusive long-clinging oil film . . . which lubricates, softens, prevents excessive moisture evaporation and so helps to replenish natural oil and moisture.

ECONOMICAL In addition, the cost per application of SARDO is low – for only **one** capful per bath is required for therapeutic effect.

PLEASANT Unique pine scent, non-sticky, non-sensitizing, SARDO assures patient cooperation.

SARDO consists of oils and various esters of specially selected organic acids having a chain length of C-14 and 16 in combination with non-irritating wetting agents to provide colloidal dispersion of the lipophilic phase. Fragrance consists of natural essential oils, isolates, and aromatics.



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Also available: SARDOETTES, disposable compresses impregnated with SARDO, for topical application in relieving skin dryness, itching, scaliness in the same conditions as listed for SARDO.

1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58:3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961.

* Pat. Pend. T.M. © 1962 by Sardeau, Inc.



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

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*Schwartz, I. R..
Current Therap. Res. 3:29, Feb., 1961.

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TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
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Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

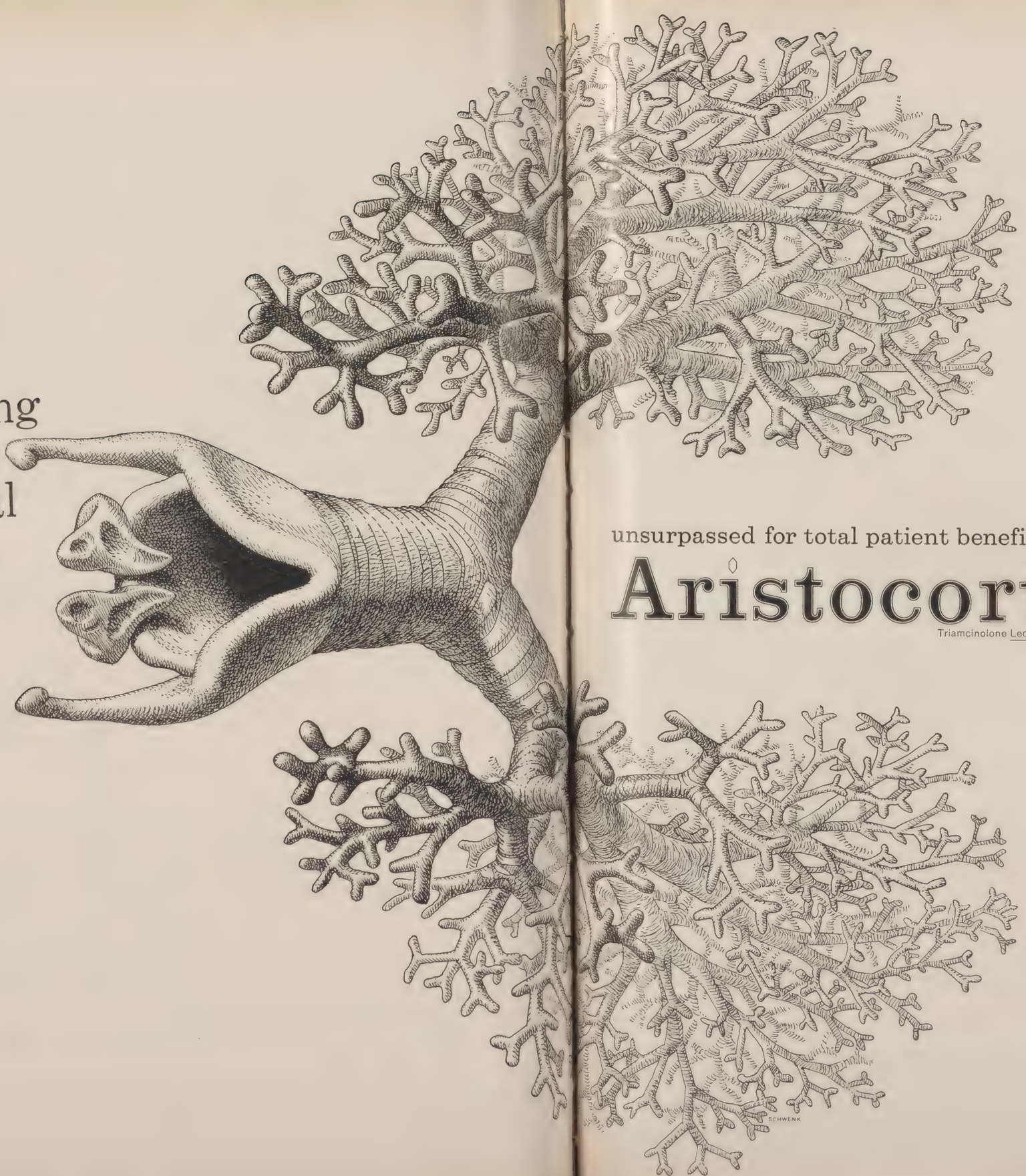
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relief
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unsurpassed for total patient benefits

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With ARISTOCORT, asthmatic patients obtain sustained relief of wheezing, dyspnea, and spasmodic coughing. It is of particular value in ameliorating severe attacks that may have serious sequelae. With ARISTOCORT, many patients who might otherwise be invalids are able to continue their customary livelihoods or maintain their regular household activities. Yet this symptomatic relief is not often accompanied by the hormonal collateral effects —sodium retention, edema, emotional disturbance, insomnia, voracious appetite— that so often have been a deterrent to steroid therapy.

SUPPLIED: Scored tablets (three strengths), syrup and parenteral. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

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Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

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Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*

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Terramycin® capsules • syrup • pediatric drops
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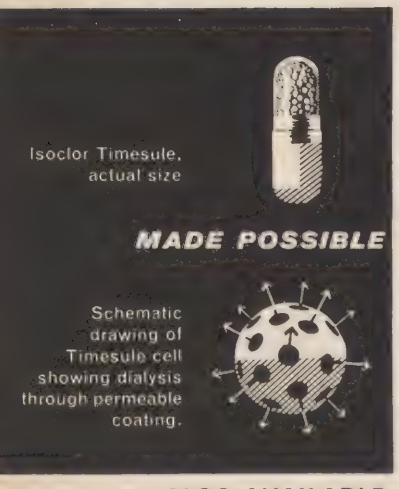
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A NEW COMPREHENSIVE RELIEF

- **Relief usually starts in minutes**—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- **Relief usually lasts up to 12 hours** with a single oral dose
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- **With minimal** drowsiness, CNS or pressor stimulation



ALSO AVAILABLE:
ISOCLOR TABLETS AND LIQUID.

MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

EACH ISOCLOR TIMESULE CONTAINS:
Chlorpheniramine maleate ..... 10 mg.
d-Isoephedrine HCl ..... 65 mg.
In a special form providing prolonged therapeutic effect.

DOSE: Adults: One Timesule every 12 hours, or as directed.

WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

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THIS IS THE COLOR OF PROTECTION



BETADINE—The only germicide whose color indicates a germ-free environment—provides lasting protection and is the most potent non-irritating topical antiseptic known.

for the first time...
a universal microbicidal agent that does not sensitize or retard healing

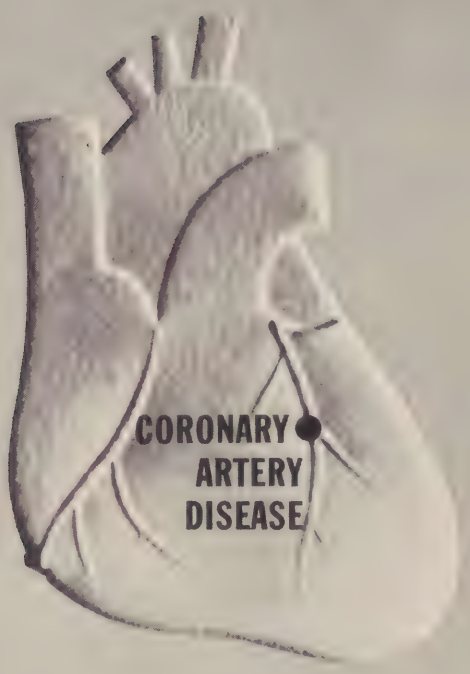
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Kills bacteria, viruses, fungi, yeasts and protozoa on contact. Non-injurious to skin, exposed tissue or mucous membranes.

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PHYSICIANS PRODUCTS CO., INC.
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• "...now the leading cause of death in diabetic patients."[1]

Diseases of the cardiovascular-renal system account for about three-fourths of deaths among diabetic patients, with heart disease responsible for approximately one-half the total,[2,3] and coronary atherosclerosis the major cause of cardiac lesions.[1] While some feel that diabetics are predisposed, perhaps by heredity, to early onset of vascular disease, considered opinion is that vascular degeneration can be delayed or modified with "...careful and consistent control of diabetes from the time of diagnosis...."[4]

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for quantitative estimation

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urine sugar

- continued, close control
- graphic *Analysis Record* encourages co-operation...reveals degree of control at a glance...helps patient maintain control

for "yes-or-no" enzymatic testing

new, improved

DIP AND READ **clinistix®**

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10-second reading...longer strip for easier handling...new color chart and color barrier for test area...in glass for protection

Supplied: CLINITEST Urine-Sugar Analysis Set (with bottle of 36 tablets and 2 foil-wrapped tablets); refill boxes of 24 Sealed-in-Foil Reagent Tablets and bottles of 36 tablets. CLINISTIX Reagent Strips in bottles of 60.

References: (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes *9*:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) *6*:611-612, 1961.

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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.

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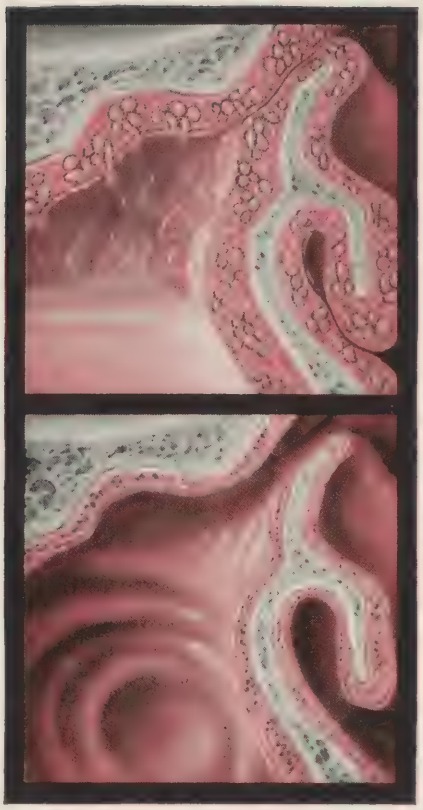
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. **2.** Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. **3.** Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958.

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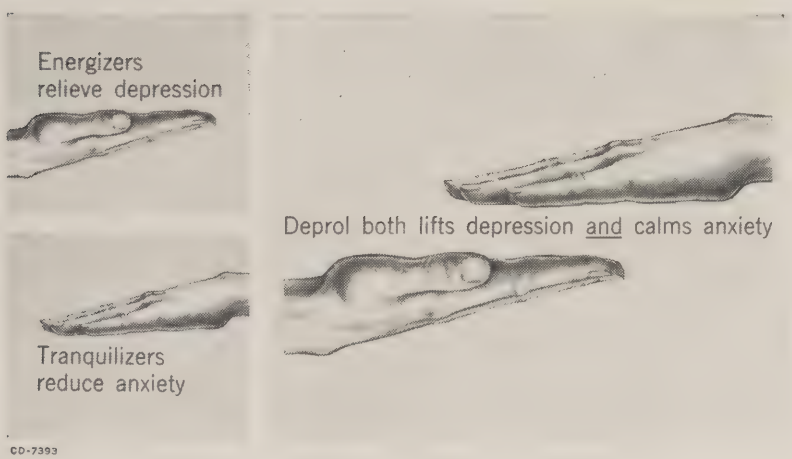

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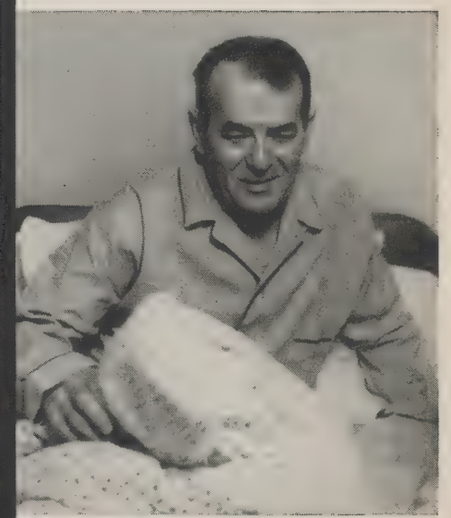
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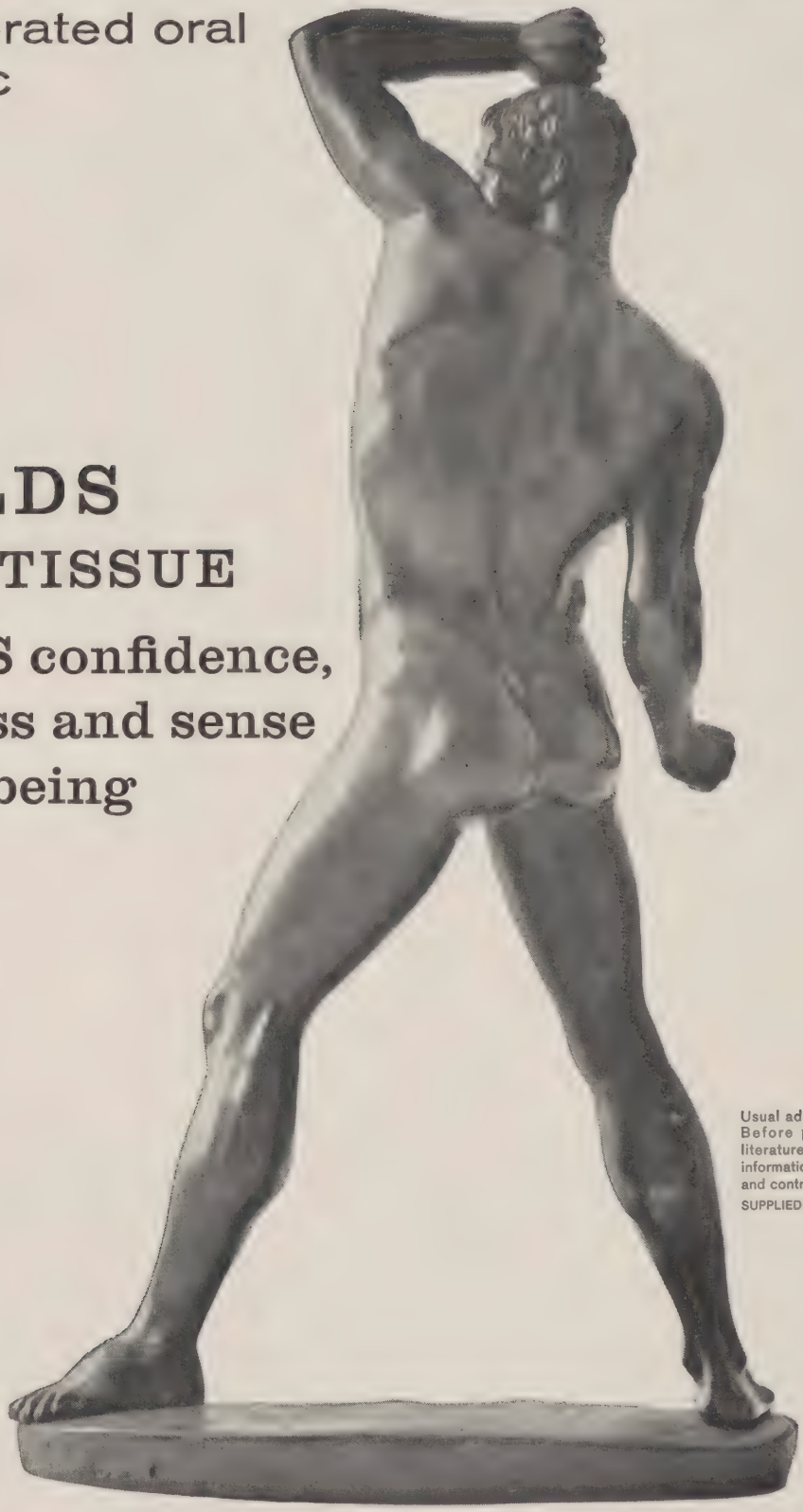
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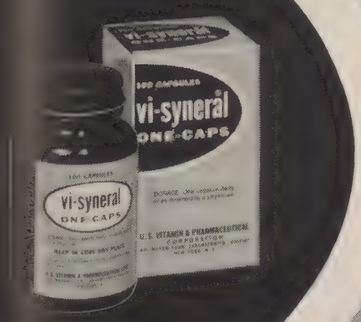
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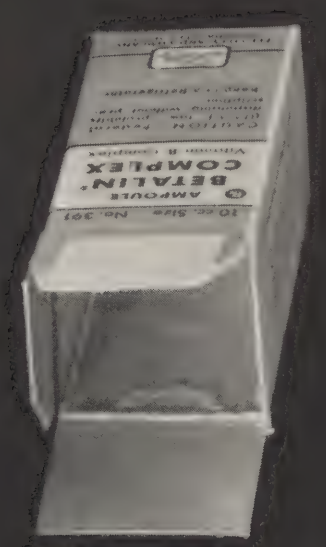
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MASTOPLASIA AND CANCER OF THE BREAST

A REVIEW

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There has been much investigation and controversy over the relationship of cancer to the proliferative disease called variously mastoplasia, fibrocystic disease and chronic cystic mastitis.

The degree of confusion as to the etiology and pathogenesis of mastoplasia finds mute testimony in the multiplicity of nomenclature. However, since better techniques of purification of endocrines and of experimentation are now available, the view that improper balance between the stimulating effect of estrogen and progesterone on the control of mammary growth is coming more and more into general acceptance as the cause of the disease. Not only does estrogen vary in ability to stimulate mammary growth,[1] but also the absolute quantities of progesterone and estrogen are crucial factors.[2]

Since the association was first noted by Astley Cooper in 1845,[3, 4] the fact that there is a relationship between cancer of the breast and mastoplasia has won widespread acceptance.[5, 6, 7, 8] Nonetheless, as in all types of cancer, there are puzzling questions, such as: what about the many women who have mastoplasia and never have cancer of the breast?

It has become increasingly evident that if one hopes to find a single cause of cancer which will obey a set of imposed criteria as do bacteria in Koch's postulates, one is doomed to failure and disappointment. It must be expected that as our knowledge of pathogenesis of cancer grows, we will find that the initiation and maintenance of unrestricted growth is a product of several factors in synergism.

As the literature on mastoplasia and cancer of the breast is reviewed, it becomes evident that the factors entering into the production of cancer of the breast fall into three groups: I. Genetic stimulation; II. Viral stimulation; III. Endocrine stimulation.

I. *Genetic Stimulation*

There are numerous reports of hereditary aspects of cancer in humans, but the elaborate experimental studies of Maud Slye[9] on the incidence of tumors in mice has had great influence in establishing the scientific acceptance of the theory.

Over many years she conducted experiments involving 75,000 mice. In the course of these studies 5,000 to 6,000 tumors were studied and the mice fell into three groups:

1. Those that are wholly resistant to cancer;

2. Those that do not have the disease themselves, but transmit cancer susceptibility to some of their posterity;
3. Those that are themselves susceptible to cancer.

Not only do the hereditary aspects of cancer of the breast continue to be emphasized,[10, 11] but it has been suggested that it behaves as a mendelian dominant for females and not for males.[12]

II. *Viral Stimulation*

The work of Maud Slye was confirmed by J. J. Bittner[13] who made the additional observation that in the breeding of mice, mothers from high incidence strains and fathers from low incidence strains produced progeny with a high incidence of tumors. On the other hand, mothers from low incidence strains produced progeny of low incidence when bred to fathers of high incidence strains.

Further studies by Haagensen and Randall[14] showed that foster nursing of low incidence strain progeny by high incidence strain mothers produced 76% tumors in females while control animals failed to produce tumors. Further, it was shown that as little as 0.2 ml. of milk from high incidence strain mothers was sufficient to induce the tumors.

The work of these investigators popularized the theory that the "Milk Factor" was responsible for cancer and gained such widespread acceptance that many physicians advised mothers to use artificial feeding to prevent cancer of the breast.

While work remains to be done, the available evidence indicates that the active principle in the "Milk Factor" is a virus.[15,16]

III. *Endocrine Stimulation*

With the report by Lathrop and Loeb in 1916,[17] the influence of endocrine stimulation by estrogens and the corpus luteum on the induction of cancer of the breast began to be acknowledged.[18, 19] It has been shown that castration of female mice below 6 months of age reduced the incidence of cancer, and before 15-22 days of age prevented[20] the development of cancer of the breast. That endocrine preparation of the breast by at least 16 cycles of estrogen-lutein stimulation is necessary for the development of the malignant process, was pointed out by Auchincloss and Haagensen.[21]

Five thousand examples of breast lesions studied in this laboratory over a period of several years were re-examined and tabulated in an effort to determine whether there may be gradations from the simple lesions through various stages to preinvasive carcinoma and finally to frank carcinoma. We were able to trace the gradations through the stages of desquamative epithelial hyperplasia of Cheattle and Cutter, through the papillary adenosis of Schimmelbush to frank invasive carcinoma. It is, however, impossible to establish the time

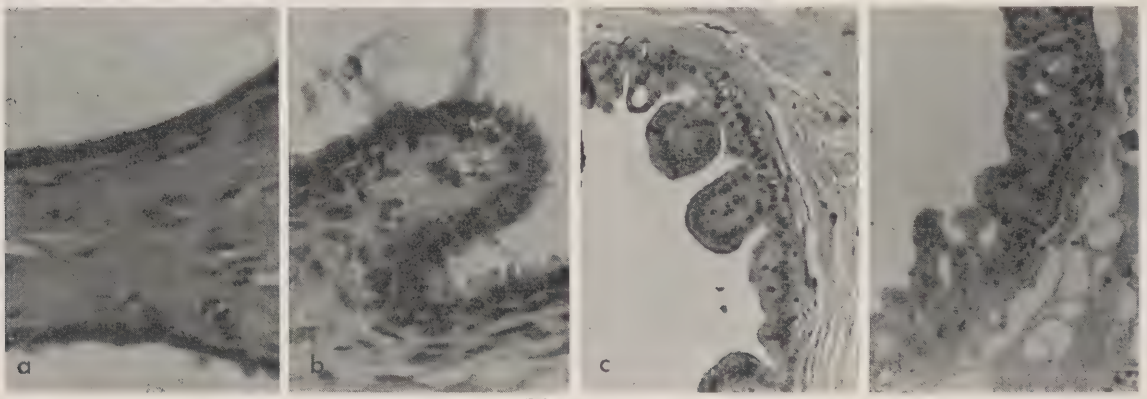


Figure 1

Photomicrographs of examples of mastoplasia arranged in ascending order of severity from the bluedome cyst of Bloodgood at A (x 740), showing proliferation of epithelium producing a papillary projection in B (x 740), becoming multiple in C (x 250), and showing daughter cyst spaces beginning in upper C and growing multiple in D (x 250). It will be noted that the cytoplasm of cells in C and D show an apocrine effect.

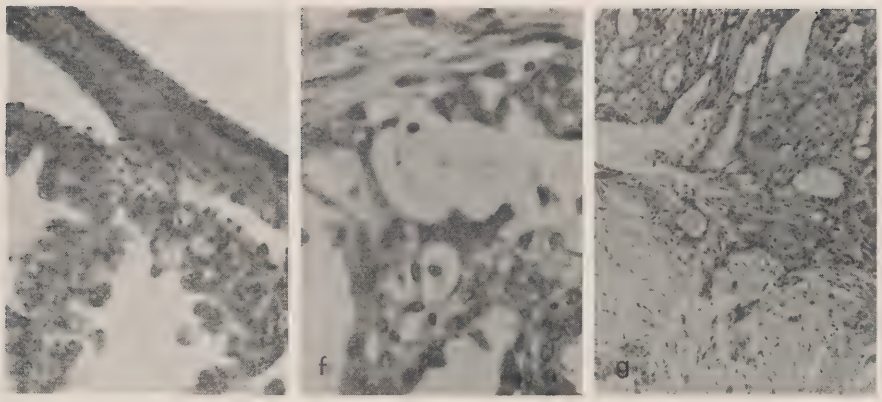


Figure 2

Photomicrographs of examples of mastoplasia showing continuation of the complexity of proliferation with exaggeration of the papillary growth in E (x 250) and cytologic changes in F (x 740) with finally atypicalities and fibrous tissue stimulation at G (x 185). The lesion pictured in G is frequently difficult to differentiate from frank carcinoma and constitutes a Schimelbusch form of the lesion.

relationship of this development — if, indeed, there is a sequential pattern. (Fig. 1 and 2)

Comment

As one reviews the factors related to the production of cancer of the breast, one is more and more impressed that the comment of Lacassagne in 1936[22] is still unfortunately true:

> "In spite of innumerable investigations it has not yet been possible to establish the existence of a strictly specific characteristic of a cancer cell either by way of morphology, immunology, chemistry or physiology other than a loss of subordination to the rhythm of division."

The transformation of a cell from a normal cell to a malignant one must be a release of growth potential[23] brought about by a combination of factors.

In the case of carcinoma of the breast, it seems logical to assume that three factors are necessary in synergism: They are stimulation by a virus of a cell rendered competent to react, hereditary composition of chromosomes, and a susceptible stage of abnormality resulting from abnormal stimulation by estrogen and progesterone.

Since the disease mastoplasia is preeminently an expression of the abnormal stimulation by estrogen and progesterone, it follows that mastoplasia is a precancerous lesion. Further the severity of this hormonal imbalance is reflected in the degree of abnormality of epithelial growth. It should be possible, therefore, for prediction of the imminence of the cancerous development to be obtained from proper evaluation of the lesion in mastoplasia.

Conclusions

1. The factors entering into the induction of cancer of the breast are reviewed.
2. The gradations in severity of epithelial dysplasia in mastoplasia are illustrated.
3. It is suggested that a combination of viral, hereditary, and endocrine stimulation is necessary for the development of cancer.
4. It is suggested that mastoplasia as an expression of the necessary endocrine stimulation determines its status as a precancerous lesion, and that the degree of epithelial dysplasia is proportional to the imminence of the development of the malignant process.

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Reflections on tonometry and glaucoma. J. W. Jervey, Jr. Southern Med J 55:685-688, July 1962.

The author puts in a very strong plea for continuing use of and confidence in old and reliable methods of diagnosing and treating the glaucomas. He encourages familiarity with the newer and more exotic methods, but urges widespread reliance on the Schiotz tonometer as the most usable and practical instrument yet devised. He gives his own personal technique in tonometry which will interest some who may not have settled on their own permanent method.

The effect of long operations on serum sodium concentrations. R. R. Bradham, H. B. Gregorie, Jr., R. E. Jackson (Charleston) Arch Surg 84:487-490, May 1962.

This study was undertaken to determine the influence of mechanisms active during an operation which would influence the serum sodium concentration by causing a gain or loss of either water or sodium. Twenty-five patients who underwent an operation of several or more hours' duration were observed for serum sodium concentration and serum osmolar changes occurring between the immediate preoperative and immediate postoperative periods. A significant change in serum sodium concentration was considered to be 5 mEq. per liter or more. Such a change occurred in 10 cases. In 8 of these the serum sodium concentration increased and in 2 it decreased. By correlating the serum osmolar changes with the serum sodium concentration changes, an attempt was made to determine the mechanisms whereby these occurred. Results indicated that during the operation on several patients there was a sodium loss. During several other operations, there was water gain causing dilution hyponatremia. Serum sodium determinations in the immediate preoperative and postoperative periods will be helpful in managing the patient who is to have an operation of several or more hours' duration.

INSULINOMA IN A 69 YEAR OLD WOMAN

A CASE REPORT

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In 1927 Wilder, Allan, Power and Robertson[12] reported a case of carcinoma of the pancreas with metastases to the liver associated with hyperinsulinism and hypoglycemia. In 1929 Howland, Campbell, Maltby and Robinson[6] reported a case in which Roscoe Graham had removed the first recognized benign pancreatic islet cell tumor with complete relief of symptoms of hypoglycemia. In 1944 Whipple[11] reported that over 149 cases of islet cell tumors with associated hyperinsulinism and hypoglycemia had been observed. In 1950 Howard, Moss and Rhoads[5] reported 398 cases of islet cell tumors, collected from the world literature. Of these 398 cases, 78.6 per cent were benign, 12.1 per cent were suspicious for malignancy and 9.3 per cent frankly malignant. Multiple tumors were observed in 12.6 per cent of the cases. Subsequently, Moss and Rhoades[7] were able to report a total of 766 cases of proven islet cell tumors collected from the world literature prior to January, 1958.

In 1960 Sieracki, Marshall and Horn[9] reported 29 cases of pancreatic islet tumors. Of the nine showing definite organic hypoglycemia, eight showed benign islet cell tumors. Of 18 non-functioning tumors, 11 were benign and seven were malignant. These authors noted that morphological distinction between benign and malignant tumors was difficult except with frank invasion or metastases. Follow-up studies revealed that the well-localized tumor usually behaved in a non-malignant fashion. These authors also noted that the tumor of less than 0.5 cm. in size is generally not physiologically functional. Their smallest functional tumor was 1.1 cm. in diameter. This is not in agreement with Cattell and Warren[2] who noted in 1953 that there was little relationship between size and physiological activity. They state that severe symptoms have been noted in a patient with an islet cell tumor only 0.25 cm. in diameter. Brunschwig[1] in 1940 removed the largest islet tumor on record measuring 15 x 13 x 10 cm. Yet, the intensity of hypoglycemia was not significantly different from that in smaller islet cell tumors.

According to Howard, Moss and Rhoads,[5] the incidence of functional islet cell tumors is about equal in male and female and the majority of cases fall between the ages of 35 and 60. However, there have been cases reported between ages 6½ weeks and 84 years. The average fasting blood sugar was noted to be 32 mg. per 100 ml.

The locations of functional tumors are almost equally divided throughout the pancreas with a slight preponderance in the tail. According to Duff,[4] 90 per cent of patients under 30 years of age with islet cell tumors have associated severe hyperinsulinism. Conversely, in patients above 60 years, islet cell tumors are rarely associated with hyperinsulinism. Cattell and Warren[2] explain this immunity

with increasing age by noting that hypoglycemia leads to surgical exploration, whereas the non-functioning adenomas remain unrecognized.

Howard *et al.*[5] further reported in the series that of all patients undergoing removal of an islet cell tumor 79.5 per cent experienced relief of hypoglycemic symptoms. Excluding those who succumbed to operation, the percentage rose to 87.3 per cent relief of hypoglycemic symptoms. The majority of patients were "diabetic" for 3 to 5 days after excision of the tumor but only 4 in the series were permanently diabetic. The mortality rate for simple enucleation of the tumor in 153 cases was 9.5 per cent. In the same series subtotal resection of the pancreas was performed in 48 patients with a mortality of 8.3 per cent.

Islet cell tumors are usually smooth, round, firm and well encapsulated. Microscopically they appear as massive islets of Langerhans with relatively normal architecture. The individual cells resemble normal mature islet cells.

Clinical Evaluation of Hypoglycemia

Organic hypoglycemia is a symptom complex which occurs repeatedly in a periodic fashion. Symptoms may include headaches, visual disturbance, mental confusion, fainting, unconsciousness, coma and convulsions. Transient hemiplegia, manic depressive behavior and permanent neurological changes may be observed. All cases of organic hypoglycemia are marked by low blood sugar in the fasting state and the blood sugar shows a progressive decline as the fasting state continues. Fasting blood sugar levels below 40 mg. per 100 ml. usually indicate hyperinsulinism.

Kenneth Warren[10] states that there is no typical response to the glucose tolerance test in an insulin-producing islet cell tumor and does not put much reliance on its values. He recommends a prolonged fasting test from 12 to 14 hours, allowing hypoglycemia to develop to the point of confusion and drowsiness. Blood sugar readings in such cases should be below 50 mg. per 100 ml. If symptoms do not develop after 24 hours of fasting, supervised muscular activity may be added to help produce an attack. Other causes for organic hypoglycemia must be ruled out. These include the following: hepatic disease (severe cirrhosis, severe acute hepatitis and Von Gierke's disease), endocrine disorders (anterior pituitary hypofunction, adrenal cortical hypofunction and hypothyroidism), large fibromas and sarcomas of the chest, mediastinum, abdomen and extremities, and finally central nervous system disorders.

Warren[10] adds to Whipple's triad and summarizes six criteria as indication for abdominal exploration. These are as follows:

(1) Attacks must come on during periods of fasting or extensive exertion.
(2) Blood sugar during an attack must be below 50 mg.
(3) Symptoms must be promptly relieved by administration of dextrose.
(4) Symptoms must be severe enough to cause stupor or unconsciousness.
(5) Other diseases causing hypoglycemia must be excluded.
(6) Self administration of insulin must be ruled out.

The following case is unusual because of the age of the patient—(69 years). Most islet cell tumors producing hypoglycemia occur between the third to the sixth decade.

Case Report

A 69 year old widowed white female was admitted to the neurosurgical service of the Greenville General Hospital on March 20, 1962 with a history of recurrent episodes of disorientation and unconsciousness for two weeks. She was well until five years prior to admission, at which time she began to experience weakness and vertigo when she would omit a meal or eat late. She was seen by two private physicians in the past two years who stated that she had low blood sugar and prescribed a diet divided into six meals a day. For two weeks prior to admission her symptoms became more frequent and pronounced. She was noted to be mentally confused before breakfast and late in the day unless additional food was ingested. Symptoms would begin with vertigo and numbness in the hands, then progress to flaccid paralysis of all extremities and unconsciousness. These symptoms were promptly relieved by orange juice or any foods. She never had seizures with these episodes. There was a negative history of jaundice, exposure to hepatotoxins or injection of insulin. There was a two year history of occasional epigastric burning, worse at night, and partially relieved by milk and

antacids. The patient had experienced marked weight gain in the last two years. The past history and family history was otherwise not remarkable. No other members of the family suffered from a similar condition. The patient was on no medication.

She had a blood pressure of 170/110 mm. Hg.; Pulse—86; Respiration—20; Temperature 98.2° F.

The patient was a moderately obese white female disoriented as to time, place and person. (Immedately following ingestion of orange juice, the patient's disorientation cleared completely). Except for a few crepitant rales in the right lung base posteriorly and slight pitting edema of the lower extremities, the examination was negative.

Significant preoperative laboratory and x-ray data included:

Admission Hgb.—13.8, Gm./100 ml. WBC—7,900. differential—85 segs 12 lymphs, 2 monos and 1 eosino. The urinalysis was negative except for 15 to 20 WBC's per h. p. f. on voided urine specimen. Total eosinophil count—143. Blood urea nitrogen 10 mg. per 100 ml. Fasting blood sugar x3 was 38, 34 & 26 mg. on separate mornings. The two hour post prandial blood sugar—88 mg. The glucose tolerance test revealed: Fasting blood sugar—24 mg.: ½ hr.—64 mg.: 1½ hr.—106 mg.: 2½ hr.—146 mg.: 3½ hr.—80 mg. Cholesterol—240 mg. per 100 ml. Serum bilirubin—0.42 mg. Alk. phosphatase—3.3 S. J. R. units. Prothrombin time—100%. Total protein—7.5 Gm. per 100 ml. with A/G ratio 4.1/3.4. Bromsulfalein—5.2% retention at 45 min. Na—144, K—4.3, Cl—112.5, CO_2—24, Vol. P—2.7, Ca—9.2 Gastric analysis (12 hr. overnight 400 ml. volume—33 units free acid and 63 units total acid. Thorn test revealed 44 eosinophils fasting and 11 eosinophils 4 hr. after ACTH injection. Protein bound iodine—6.7 mcg. per 100 ml.

The chest film was negative. X-ray examination of the gastro intestinal tract was normal except for a small hiatus hernia. Intravenous pyelograms revealed normal kidneys and ureters. The skull series showed a suggestion of demineralization of the floor of the sella. The electrocardiogram was reported normal. An electroencephalogram was reported as showing general dysrhythmia. Visual fields were completely normal.

Clinical Course: The episodes of weakness and confusion in the hospital were uniformly reversed with orange juice or intravenous dextrose. For three days before operation the patient was given ACTH, 40 units intramuscular every eight hours. On April 3, 1962 under general endotracheal anesthesia the abdomen was explored via an upper transverse incision. The hiatus hernia was palpated. Examination of the gall bladder revealed tense thickened walls with multiple large stones palpable within the gall bladder. The other abdominal organs were normal. No retroperitoneal masses could be felt.

The gastrocolic ligament was divided and the lesser sac entered. In the mid-body of the pancreas on the anterior surface there was noted a 2 x 2.5 cm. brownish smooth encapsulated mass. Extensive examination of the head and tail of the pancreas revealed no further masses. The mass was enucleated without difficulty and submitted to the department of pathology for a frozen section. The report returned was (1) probably aberrant spleen and (2) a 6 mm. nodule, attached to the main mass submitted, which was consistent with an insulinoma and (3) insulinoma probably extending to the margin of resection. Despite the fact that insulinomas can usually be enucleated without danger of leaving tumor behind, it was elected to perform a subtotal resection of the pancreas. A splenectomy was first performed. Then the tail and most of the body of the pancreas was resected back to within 2 cm. of the superior mesenteric artery. The transected pancreatic duct was cannulated for identification and tied off with free and stick ties. The open end of the pancreas was then closed with transverse mattress sutures. At the completion of the pancreatectomy, the gallbladder, which was felt to be subacutely inflamed, was removed without difficulty and the abdomen was closed in layers with 2-0 interrupted cotton and several interrupted wire retention sutures.

The final microscopic report indicated that the original 2 x 2.5 cm. tumor was an islet cell tumor. No other islet cell tumors were discovered in the body or tail of the pancreas. The gall bladder was reported as showing chronic cholecystitis with cholelithiasis.

The patient experienced a benign post operative course. The intramuscular ACTH was continued in decreased dosages for 7 days post-operatively. On the third post-operative day, she began walking with assistance and on the fourth post-operative day she tolerated liquids orally. The fasting blood sugar and glucose tolerance values returned toward normal. On the 10th post-operative day the Penrose drains from the splenic and pancreatic beds were removed and a No. 18 red rubber catheter inserted in the tract to keep it open. There was a moderate amount of thick whitish drainage following the insertion of the red rubber catheter from which on the 14th post-operative day were cultured proteus and aerobacter sensitive to chloramphenicol. On the 16th day, she had one spike of fever to 101°. The left flank drainage was thick and copious and was best controlled by a sump drain attached to a bedside suction pump. All drains were removed on the 21st post-operative day. A chest film on this day revealed a slight amount of pleural reaction at the left base. The patient was discharged on the 23rd post-operative day to be followed in the surgical clinic.

On the 28th post-operative day, she was seen in the clinic. She felt fine, had had no chills or fever, was eating well and had experienced no further episodes of weakness or fainting. There was still a small amount

of spotting on the bandage over the left flank drainage site.

The patient was again seen 2½ months after operation. She felt well and could omit meals without ill effects. The left flank drainage site had completely healed. A glucose tolerance test done on that day was within normal limits.

Significant post-operative laboratory data included the following:

1st day after operation Bl. sugar	175
4th day after operation Bl. sugar	158
6th day after operation Bl. sugar	96 and 144

9th day after operation glucose tolerance test:

Fasting sugar—99, in ½ hour—172, in 1 hr.—206, in 2 hr.—179, in 3 hr.—112.

21st day after surgery glucose tolerance test:

Fasting sugar—100, in ½hr.—166, in 1 hr.—202, in 2 hr.—200, in 3 hr.—172.

After 2½ months glucose tolerance test:

Fasting sugar—96, in ½ hr.—118, in 1 hr.—144, in 2 hr.—134, in 3 hr.—118.

Comments

Conn and Seltzer[3] and Porter and Frantz[8] in separate reports recommend the intramuscular administration of ACTH before and after surgery. The reasons given are (1) ACTH elevates the blood sugar by inducing resistance to the activity of excessive quantities of insulin and (2) ACTH seems to prevent the mysterious idiopathic hyperthermia which caused 5 of the 18 post-operative deaths in cases reported by Howard *et al.*[5] All of these hyperpyrexia deaths occurred within four days after operation. In the case reported above the ACTH was continued for 7 days post-operative. The only significant post-operative temperature elevation (101°) occurred on the 16th day and was probably related to the purulent drainage from the left flank.

Summary

A case of a benign insulin-producing tumor with associated severe hypoglycemic episodes in a 69 year old female has been presented. Following surgical removal of the tumor the patient recovered with no evidence of hyperinsulinism or diabetes.

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Pseudosarcomatous fasciitis. Furman T. Wallace, M. D., Richard S. Wilson, M. D. (Spartanburg) and James R. Cain, M. D. (Columbia) Southern Med J 55:475 May 1962.

Unnecessarily radical surgery has been done in the past for a condition which now seems well on its way to being proven benign. The lesion is pseudosarcomatous fasciitis. It is first manifest as a tumor which usually appears in the extremities. The pathologic diagnosis of the nodule removed for biopsy in the past was often of sarcoma. When the surgeon received this report, a radical operation usually was done with wide excision, with skin grafting and in some instances radical dissection of lymph nodes. The surgeon was really obliged to do such radical surgery since the diagnosis was sarcoma. However, now that the condition is recognized as probably benign, it is not necessary to do more than a local excision of the nodule. It is now believed that this is an inflammatory reaction rather than a true tumor.

Pseudosarcomatous fasciitis was first described by Konwaler in 1955. It is a distinctive clinical-pathologic entity, and its recognition is very important to the proper management of the case.

WHAT THE PHYSICIAN CAN DO ABOUT PREVENTING ACCIDENTS TO CHILDREN

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Recently Dr. Julian P. Price, when Chairman of the American Medical Association's Board of Trustees, pointed out that accidents are the chief cause of death among children under 15, and called on physicians to assume leadership in an educational campaign of prevention. Actually, physicians, individually and in organized groups, have in the past decade already demonstrated beyond a doubt that the medical profession has an essential role to play in community and nationwide accident prevention efforts. It will be the purpose of this paper to summarize some of the results of medical participation in accident prevention and to suggest opportunities for further contributions.

In contrast to the sharp drop in diseases of childhood, the death rate for accidents has shown only a slight decline in the past thirty years. In the years since 1950, coinciding with growing activity of physicians in accident prevention, mortality from accidents of all kinds decreased by 18 percent among boys between 1 and 4 and 12 percent among girls of the same ages. Between 1950 and 1958 at ages 5-14, accidents declined 17 percent among boys and 13 percent among girls.[1] This is hardly a spectacular result but it does provide some encouragement for greater action. This has been accomplished in spite of an increase in our child population amounting to more than three million in the 0-4 age group and close to 10 million at ages 5-14.[2]

The Problem Today

Not only are accidents the leading cause of death among children and young people in the United States, but also in Canada, many European nations, and even in some of the under-developed areas of the world.

Presented at the Annual Meeting of the South Carolina Medical Association. 1962.

In child accidents, mortality rates, like the visible part of an iceberg, present only a fraction of the menace. To better comprehend the magnitude of this problem, we must take into account all the broken bones, burns, cuts, bruises and nonfatal poisonings that occur daily—many of them serious enough to cause crippling or disfigurement. In the United States, one out of every three children under 15 is injured in an accident every year severely enough to see the doctor or restrict activity for a day or more.[3] Some 17 million children under 15 are injured accidentally every year in the United States.[4] This is a ratio of more than 1,000 nonfatal accidents to every fatality. And bear in mind this is not the whole story of the accident problem. Death or injury are in fact the end results of an accident. To measure, as well as solve this threat to child health, we must also concern ourselves with those situations when children barely escape injury.

An International Problem

In 1956 the WHO Regional Office for Europe brought together for the first time a study group from European countries to consider the prevention of accidents in childhood. Reports at that meeting[5] as well as the follow-up conference held in 1958 indicate that programs of prevention are being developed in many countries, including those behind the Iron Curtain.

As nations improve sanitation, nutrition, and maternal and infant care, accidents become the top-ranking cause of death in childhood. The WHO publication on Childhood Accidents is a basic document for any nation which intends to study its child accident problem.

In addition to the progress made in the con-

trol of infectious diseases and nutritional deficiencies, another reason for the emergence of childhood accidents is modern technology. The spread of electrification, the increasing use of pesticides and household chemicals, the growing number of motor cars, farm machinery, and other equipment have introduced new and dangerous hazards into many homes and communities. A third reason is interest in the problem. As population statistics and mortality and morbidity data are acquired even in underdeveloped areas, accidents are discovered to be a significant health problem. For example, recently in reporting on population studies in India, Gordon and Wyon[6] found accidental traumatic injury to be the first cause of death among children in a rural section of the Punjab. Comparable reports have been made by Castellano for quite primitive sections of Venezuela.

What Do We Know?

Most of what we know about accidents to date is concentrated in statistical counts—how many deaths and serious injuries occur; what they are—falls, burns, smash-ups; where they happen—at home, at school, on the road, in public places; at what ages certain types of accidents are most numerous. We know that other variables, including sex, geography, time of day, and season of the year all help determine both the number and type of fatalities or injuries.

Statistics tell us the size of the problem, and have led to active programs — educational, technological, and legislative — which have reduced either the incidence of a specific kind of accident or the seriousness of its results. In England, a classic example is the pioneering research of Colebrook[7] and his co-workers on childhood burns. They first identified certain specific causative agents, then stimulated a series of technological developments, e.g., flameproof clothing, nontipping tea kettles, and guards for open fireplaces. An active educational program was developed to warn against this hazard. Finally Colebrook and his associates took an active part to see that the use of some of these technological developments was subsequently made compulsory by legislative action. This is reminiscent of the work of Chevalier Jackson, Sr.[8] in this country, whose experience with lye burns of the esophagus made him a leader along with the A.M.A. in the development of the first Federal Caustic Poisons Act. More recently the American Medical Association and the American Academy of Pediatrics took an active part in developing a new Federal Act to minimize poisoning accidents, known as the Federal Hazardous Substance Labeling Act.

Even when the prevention of a certain type of accident seems remote, if not impossible, the seriousness of its consequences can be sharply reduced once quantitative studies clearly indicate its magnitude. The use of safety glass in automobiles is a good example. Others are the provision of life jackets to prevent children from drowning when boats capsize or the teaching of swimming at an early age to all children, especially those who live near or on water. Examples on a broader level include the development of poison control centers which provide immediate information on the treatment of accidental poisoning and the widespread teaching of first-aid procedures to policemen, firemen, and others who are likely to be at the scene of an accident.

Efforts to Fill Gaps in Our Knowledge

These illustrations suffice to indicate the usefulness of the information we have, but its usefulness should not cause us to overlook some of its limitations. For, although it can tell us *the number* of children who will be killed or injured in *what kind* of accident, it cannot tell us *how* and *why* these accidents happen. It does not tell us *who* these children are likely to be nor, more broadly, why some children are more susceptible to accidents than others. This kind of knowledge is essential if we are to make further significant reduction in deaths and serious injuries.

A number of important efforts are being made to fill some of these gaps. One of the most important is under the aegis of the Association for the Aid of Crippled Children. The Association has recently initiated a number of study groups in both university and non-university settings whose purpose is to stimulate

and encourage research designed to reduce accidents in childhood.[9] Several important projects have already resulted. One is a monograph by Suchman and Scherzer of current research in childhood accidents. Recently a two-day conference to explore the contribution of the behavioral sciences to accident research was held at West Point, New York.

The Society for Research in Child Development has recently published a report of a pilot study at the Tulane University Family Study Unit.[10] The results suggest that there are discernible differences between the children who suffer repeated accidents and those who do not. There was greater acceptance and affection expressed between control mothers and their children, whereas the accident group showed a greater divergence in attitudes and less mutual acceptance and affection. They came from homes where there was less harmony and more unhappiness. The study concluded that the accident pattern appears to be a symptom indicative of an emotional disturbance within an individual who relies on action as his chief defense mechanism against anxiety.

Other current research includes the epidemiological study of childhood accidents launched in 1958 in New Bedford, Massachusetts.[11]

Case histories have been collected for accidents which occurred to children five years of age and under in the New Bedford area. The data collected provide great detail concerning the accident, the characteristics of the child and the family. Analysis of the data has provided information concerning the parents' accident prevention activities as related to family and parent characteristics, including recall of safety education. Other aspects of the project are still under study.

An epidemiologic study of poisoning[12] throughout the United States was designed to develop preventive measures to counteract poisoning from various causes. Principal results were as follows:

Analysis of 14,069 cases of accidental ingestion and poisonings reported by the National Clearinghouse from 59 poison control centers shows that medicine accounts for 55 percent of these cases—the most frequently ingested medicine being aspirin. Of these reported cases, 90 percent were found in children under five years of age.

Follow-up data of 2,494 home investigations showed that at the time of the accident, the offending agent was not in its customary storage place in 71 percent of the cases, and not in its original container in 34 percent of the cases. Parents were supposedly supervising child activity in 84 percent of the cases involving children. In an additional 9 percent of the cases, the supervising individual was an adult other than the parent.

An epidemiologic study of accidents to school children is in process in Massachusetts.[12] The basic objective of this study is to determine the causes of accidents which result in injury to school children. Information concerning the school environment, accidents which occurred and the population exposed among elementary schools has been coded and is being analysed.

These are encouraging developments but more studies are needed, especially in the area of child behavior and personality. Recently the National Institutes of Health allocated one million dollars for accident research. The National Safety Council has created a top-level Committee on Research and Education and with a grant from the Metropolitan Life Insurance Company has established the first Safety Council Award for Research.

What Physicians Can do

Despite our gaps in knowledge, there is much that physicians can do. The physician's role in preventing accidents to children is manifold: to investigate accidents; to instruct parents in advance about the common hazards inherent in the various stages of the child's development; to encourage parents to teach their children how to live in the world about them effectively and safely; and to work with community groups in developing accident prevention programs. What does this mean in everyday practice?

Investigating Accidents

Detailed case histories are vitally important,

and the physician is in the best position to obtain them, to question parents or others present on the how and why of the accident. When called to treat an injury, the physician should include as part of treatment an inquiry to learn how the accident occurred. This is practicing preventive medicine. For example, a ten-year-old youngster was seen with a badly lacerated knee. The history revealed it had occurred in the school gymnasium during a bit of horseplay when the instructor had not been present. The immediate cause of the injury was the jagged edge of a radiator-cover whose repair had been long delayed. Reporting of these facts to school authorities resulted in prompt correction of the condition. This concern with the cause of accidents is as essential a part of good pediatric care today as outlining a well-balanced diet or providing immunization.

Parent Education

Does the young mother or the grandmother of a two-year-old know the typical behavior and interests at this age? Do they know at this age that eager and restless impulses may take the youngster alone into the driveway? Or that open electric sockets are inviting to a curious toddler? Or that the little runabout has no knowledge and therefore no fear of the hazards in a modern street? Inquiring about home conditions and advising corrective and precautionary measures for such hazards at appropriate stages of growth and development is now common practice with many pediatricians. Medicine has introduced two important concepts into accident prevention education in childhood. First was to recognize the importance of the child's stage of growth as a major contributing factor not only to accidental injury but also to the type of accident. This concept has been fundamental in helping those who supervise the child to anticipate and thus prevent accidents. The second contribution has been to re-establish discipline as an important technique in child safety education. To avoid injury and to cope with his modern world, the child must learn to obey rules of conduct. As he learns the correct way of doing things, he learns the safe way.

There have been a number of "teaching aids" prepared to assist the physician with this parent-education function. One of the earliest and still very useful is the booklet, *A Formula for Child Safety,* available through the Metropolitan Life Insurance Company. This incorporates the principles of anticipatory guidance. Since it was first published in 1952, 2,222,000 copies have been distributed, many by physicians and nurses. Using this same principle, a set of accident prevention leaflets, a sheet for each important period of growth under five years of age, was brought out by the American Academy of Pediatrics. Most recent is the same organization's booklet, *Obedience Means Safety for Your Child.* Within a few months over 400,000 have been requested. These are by no means all the educational material available to physicians, but illustrate the type of publication available to you and to parents.

All of these educational materials emphasize that parents must (1) protect young children from accidental injury; and (2) conduct an expanding program of education. The infant and very young child must have close supervision and protection, but maximum prevention of childhood accidents cannot be accomplished only by protection. As soon as the child begins to understand, usually about the second year, parents must begin to teach the child how to protect himself from the common hazards of his immediate environment. At the age of five or six, children should be ready to assume increasing responsibility for their own safety as they go back and forth to school and during their play.

Parents need to be reminded that much of this teaching is done "by example." Parents who cross the streets or drive through red lights or speed up to "slip by" on the caution signal, cannot expect their children to obey pedestrian and bicycle traffic rules. Indeed because of the emphasis on safety in some school programs, it is not uncommon that children point out imprudent safety conduct to parents. Physicians would do well to suggest that parents review their own safety conduct very carefully—lest "a little child shall lead them."

The school physician has an important role in the safety of the students. Medical judgment can contribute to the study of accidents which occur at school, at home, at play, or on the highway. Accidental injuries adequately reported on the student's health record can provide useful information in defining needed areas for safety education.

Safety is in essence a part of human behavior—it involves the way a person lives and acts. It should not be treated as something separate and apart from human activity. Correct behavior or performance has safety built into the act. The traffic rules for riding a bicycle are part of the "learning to ride" process. When a child learns to swim, water safety is part of the instruction. Industry no longer teaches a man how to operate the machine and then teaches him safety procedures. Safety procedures are a part of operational procedure. As the parent teaches the child and as industry instructs the worker how to avoid accidents, the school physician can use the same approach in helping educators to develop a dynamic safety education program in the schools.

Community Activities

In addition to individual patient and parent education, the physician, as teacher, can exert a powerful influence on groups of people in community accident prevention activities. People are more apt to listen to the speaker who is also a physician—knowing that he or she speaks from intimate knowledge of the tragic consequences of accidents. There are many sources of help in preparing talks on child accident prevention. *Accident Facts*, published by the National Safety Council, is a gold mine of information. Local councils, health departments, insurance companies have slides, films and other visual aids.

Physicians can also contribute by using their influence to organize the means of securing information about accidents on a systematic basis. As I have said, there are large gaps in our understanding about the way accidents occur. We are only beginning to scratch the surface of such questions as the relationship between accidents and health, personality, behavior, drugs, and many other factors. The accident rooms and traumatic services of hospitals are an important potential source of valuable information. Several years ago I suggested that some of the larger hospitals set up accident data-collecting stations.[13] Fifteen or twenty such centers or accident service stations throughout the country collecting a few basic facts on the type of injury and the agent which caused it, and reporting this to a central statistical unit would be the beginning of an intelligence service concerning trauma. This would be comparable to the reporting systems which have been developed for many diseases. Trauma has reached, so to speak, such epidemic proportions that we can no longer afford to wait for a paper to be written and then published a year or so after the author has collected fifty or sixty cases from his own experience, to learn for example that a certain type of power equipment or tool or toy or gadget or type of construction has produced an unanticipated number of injuries. This network of cooperating surgical services not only could become in time centers devoted to setting standards for the better treatment of trauma, but also could play a key role in furnishing data for programs of prevention. This kind of organized information service is comparable to the poison control system which the medical profession has sponsored and of which there are now more than three hundred located in every state in the Union.

Conclusion

Physicians have made important contributions to child accident prevention, as I have reported. There is an encouraging reduction in the accident mortality rates in this age group which has shown a steady decline since 1950. This is about the time when the medical profession, especially pediatricians, began to direct their attention to the problem. An expanded research program is needed if we are to make further substantial progress. Meanwhile the annual bumper crop of new babies is a perennial opportunity to make child safety education an integral part of health super-

vision. Indeed, in our modern world machines and toxic substances are replacing germs as the greatest environmental hazards to the growing child.

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Hemiplegic migraine: A case with paroxysmal shoulder-hand syndrome. B. M. Montgomery, (Newberry) and W. W. King, Jr., (Batesburg) Ann. Int. Med. 57: 450-455, Sept. 1962.

A case of migraine exhibiting recurrent episodes of hemiplegia of several hours to several days duration is presented. Neurologic examination was normal between attacks and carotid arteriogram, electroencephalogram and spinal fluid examination did not reveal a static intracranial lesion. The hemiplegic attacks were successfully aborted by the administration of dihydroergotamine.

The case was felt to represent major hemiplegic migraine and to support a sequence of exudation of fluid into the wall and perivascular tissues of an artery of the internal carotid system during the vasodilative phases, analagous to the similar sequence in the external carotid system. The resulting focal cerebral edema was reversible.

Coincident with the recurrent paralysis, a paroxysmal shoulder-hand syndrome was produced. It was proposed that centrifugal impulses may at times initiate the shoulder-hand syndrome and that vasomotor factors alone can produce the clinical features of the early stages.

"Scoping" the past: A search through history for the management of anorectal diseases in the late middle ages. Leon Banov, Jr., M. D. (Charleston) Southern Med J 55:846 (August) 1962.

This paper presents the management of anorectal diseases by some of the physicians and surgeons of the late Middle Ages. It is to be noted that some of our current ideas and concepts of care and treatment of anorectal diseases can be traced to the 12th, 13th, and 14th centuries. These include:

(1) The classification of external and internal hemorrhoids.

(2) The management of hemorrhoids by diet and the avoidance of purgatives.

(3) The use of warmth to reduce the pain of hemorrhoids.

(4) The demonstration of internal hemorrhoids by getting the patient to strain.

(5) The use of the knife instead of the cautery.

(6) The use of the seton.

(7) The use of the probe and the knife to lay open the fistulous tracts as described by Arderne.

(8) The fact that a perianorectal abscess preceded a fistula.

(9) The importance of doing a digital examination, especially in cases of frequent bowel movements, to diagnose cancer of the rectum.

(10) The emphasis on the surgeon being well educated, of good character, and possessing skillful hands.

The study of medical history, besides being fascinating, provides a full realization of our debt to the past, promotes moderation in evaluating our own work, and compels a greater respect for the antiquity of our calling.

Massive bleeding from a polyp in a duodenal diverticulum. Gilbert B. Bradham, M. D. and James B. Martin, M. D. (Charleston) Ann Surg 156:81, July, 1962.

A case of massively bleeding polyp located in a duodenal diverticulum is presented. The displacement of the pancreatic and biliary ducts by duodenal diverticula necessitates the need for meticulous dissection in this area. The necessity for intraluminal inspection of diverticula is stressed.

THE ROLE OF THE PLANTAR FLAP IN THE SURGICAL MANAGEMENT OF PLANTAR WARTS

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Introduction

As pointed out by Giannini[1] in his excellent presentation on the surgical treatment of plantar warts, the viral etiology of plantar warts is usually a secondary consideration to the reconstructive surgeon. By the time that the patient is referred to the plastic surgeon, the initial, contagious lesion has usually been well destroyed and replaced with a solid mass of scar tissue or a discharging ulcer which is usually more painful and troublesome than the original wart. One doctor after another has tried

1) Procaine injection
2) Curettage
3) Trichloracetic acid
4) Glacial acetic acid
5) Phenol
6) Fuming nitric acid—and, very likely, simple excision and primary closure. When the lesion recurs, it is again excised, this time more generously and left to heal by second intention. The patient is told that this time the wound must heal from the bottom out. Next, the doctor sends the stubborn wart to the radiologist who will apply either radium or x-ray or both. Since x-ray has little or no effect on mature scar tissue, no improvement results. After much discussion, it is decided to wait a while and see what happens. About this time, the patient begins to use a walking stick and later, one and then two crutches. Frantic efforts are now being made by the breadwinner's family to prove that this is a workman's compensation case. The patient now notices that the reddened area of the foot where the x-ray was applied, is beginning to blister and peel. Later a frank ulcer appears.

This is the happy situation that confronts the plastic surgeon when the patient is first seen by him. Our efforts are directed toward removal of the ulcerated and scarred tissues from the weight-bearing portion of the foot. The defect must be resurfaced in such a way that it will withstand normal weight-bearing. Conway[2] recommends the use of a thick split thickness skin graft. Greeley's[3] filet procedure



Figure 1.
Painful plantar wart overlying head of second metatarsal bone.



Figure 2.
Incisional lines outlined for wide excision of wart and development of plantar flap.

and Giannini's[1] shortening procedure involving the second toe are extremely useful. Robinson has described the use of an adjacent flap and full thickness graft with excellent results. As pointed out by Pickrell,[4] careful evaluation of the patient should rule out the presence of a displaced sesamoid bone or a shortening of the extensor tendons. If these factors exist they should be corrected by excision of the displaced bone and lengthening of the tendons at the time of excisional surgery. Pickrell[4] has also shown the advantages of removal of the plantar protuberance of the head of the underlying metatarsal bone if it seems to contribute to the condition.

Case Report

This report describes the author's technique in the management of plantar warts located in the anterior weight-bearing area of the foot.

This patient is a 41-year old, white female, who is the athletic director of a large playground district. She is very active in sports and has had no serious illnesses. She was first seen in April 1961, because of the presence of a painful lump on the bottom of the left foot. Examination revealed a typical plantar wart located over the head of the second metatarsal bone. (Fig. 1). It was exquisitely tender to palpation. The patient walked on the heel of the left foot. The wart had been present for eight months but only for the past 1½-months had it been painful.

Since this was a virgin wart, x-ray therapy was advised. Ten hundred and fifty (1050r) roentgens were applied on April 13, 1961, (100 KU, 25 milliampers). The patient stated that the condition worsened during the following 2½-months. She was admitted to St. Francis Hospital on June 28, 1961. X-ray films revealed no abnormalities of the sesamoid bones. There was no unusual shortening of the extensor tendons. Operation was performed the day following admission. Under general anesthesia, the wart was excised widely and deeply so that all adjacent and underlying thickening was removed. Fig. 2 and 3). Palpation revealed no unusual prominence of the head of the metatarsal.

Accordingly, a flap was outlined and elevated (Fig. 3 and 4) from the adjacent, non-weight bearing area of the instep of the foot and turned to resurface the defect. The full thickness graft was placed over the flap donor area. (Fig. 4). Several stainless steel wire sutures were placed around the distal end of the flap. The patient's postoperative course was uneventful and the dressings were changed on the 6th postoperative day. Since the graft was in good condition, all silk sutures were removed. The wire sutures were left in place for 14 days. Graduated weight-bearing was begun at three weeks.

The patient was seen last in September, 1962. At that time the flap and graft were in excellent condition. (Fig. 5), and the patient is back on a full athletic schedule and is asymptomatic.



Figure 3.
Wart has been excised and plantar flap elevated.



Figure 4.
Flap has been trimmed and turned to resurface weigh-bearing area of foot. Full thickness graft from groin covers the flap donor area.



Figure 5.
Result fifteen months following surgery. The patient is working full time and is asymptomatic.

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Clinics of the Month

DERMATOLOGICAL DON'TS

KATHLEEN RILEY, M. D.

Case 6—Granuloma Pyogenicum

White, Male, Age 10

HISTORY

Two weeks previously the patient noticed a "red pimple" on his chin.

It grew rapidly to one centimeter in size.

It was completely asymptomatic except for bleeding on several occasions after slight trauma.

Upon further questioning the patient did remember a scratch on his chin about the time of the onset of the lesion.

PHYSICAL EXAMINATION

On the chin was a smooth, shiny lesion of a deep purple-red color, one centimeter in size, dome-shaped.

It was sharply demarcated without extending erythema.

The area was relatively non-tender. No other lesions were present.



DIAGNOSIS

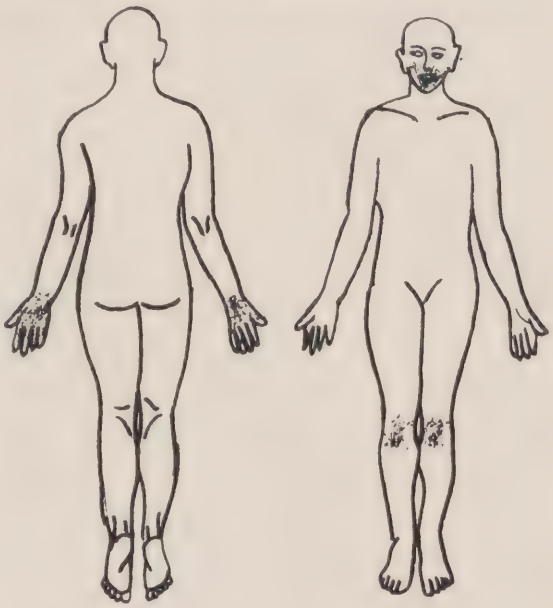
Granuloma Pyogenicum

TREATMENT DON'TS

1. Don't remove by surgery.
2. Don't treat with antibiotics.
3. Don't use x-ray therapy.

DO

1. Do destroy by electrodesiccation after simple xylocaine anesthesia.
2. Do excise lesion for biopsy if in doubt concerning the diagnosis, but electrodesiccate the base.
3. Do expect minimal or no scarring.



Common Distribution of Granuloma Pyogenicum

TOXICITY OF PHENOTHIAZINE TRANQUILIZERS

HENRY W. MOORE, M. D.

Columbia, S. C.

In recent years, the medical profession has been practically submerged with a wave of new drugs of the so called tranquilizer or ataraxoid group. While most of these drugs are primarily intended for their psycho-theraupetic effects, many of them have been widely recommended for their anti-emetic properties. This is particularly true of the many chemically related compounds of the phenothiazine class. Several such drugs have been widely detailed for their anti-emetic properties and are available in varying forms and dosage. It appears that many of this class of tranquilizers appear to carry a significant degree of danger in the *dehydrated* pediatric age patient.

The following brief case illustrates the type of toxic reaction encountered in three children who received tranquilizers (anti-emetic type) to combat nausea and vomiting apparently caused by a viral gastro-enteritis.

Case Report: A 12 yr. old husky adolescent female became ill with acute gastro-enteritis characterized by repeated vomiting and diarrhea some

three days prior to admission. She improved temporarily on symptomatic treatment, however, she again developed a severe bout of vomiting following a light diet, and had rather explosive stools and abdominal cramps. At this time her grandmother became impatient with her symptomatic medication, and requested her family physician to send her something for the child's vomiting. The physician responded with 10 mg. Compazine suppositories which were given every four hours for three doses. The child's vomiting ceased. (20 mg. of this drug is the maximal recommended dose in 24 hrs. on the patients weight basis).

Several hours later the family became alarmed and frightened when the child developed rather bizarre facial contortions and complained severely of "stiffness of the neck," and arched her neck and back in peculiar position which the family interpreted as a convulsion. They also noticed peculiar gyrations of her eyes with facial grimacing.

At this time, examination revealed a well developed, well nourished, moderately dehydrated, cooperative youngster. Skin and mucous membranes were dry. Typical Kussmaul type respirations and acetone odor to breath was noted. The temperature was 99 orally. B.P. 100/60. Pulse normal, respiration 40 to the minute.

During the examination, the patient suddenly complained of discomfort and assumed a posture of opisthotonus with marked facial grimacing and a peculiar catatonic stare. This attitude lasted for several minutes before she became relaxed with a clear sensorium. The patient also developed oculo-gyric movements of eyes and trismus during subsequent episodes with extended, hypertonic extremities. Between these episodes she complained of headache but otherwise appeared relaxed and free of muscle discomfort or abnormal neurological findings.

Laboratory findings were essentially within normal range except for increased hematocrit and acetone bodies in the urine. Spinal tap was not done inasmuch as this was the third patient seen with a similar symptom complex following over-dosage of compazine (prochlorperazine) and trilifon (perphenazine).

The patient was completely free of symptoms after 12 hours of intravenous fluids and correction of dehydration.

Summary

Tranquilizing drugs of the phenothiazine group are widely used in parenteral and suppository forms for the control of emesis, irrespective of the cause. These drugs are prone to produce symptoms of extrapyramidal mid-brain pathology (Parkinsonian symptoms) in patients with only moderate degrees of dehydration.

The use of phenothiazine tranquilizers as antiemetics would appear to be contra-indicated in the dehydrated patient. Too few physicians are aware of the relatively low margins of safety that many of these drugs seem to possess when given to dehydrated patients.

Reference: Psychochemotherpy; Remmer, Cohen et al.; Western Med. Pub. Los Angeles, Calif. 1962.

Anorectal wound healing: A comparison of the value of antibiotic agents and nitrofurazone. Leon Banov, Jr. (Charleston) Dis Colon Rectum 5:291-294, July-Aug. 1962.

In this clinical study documented by serial color photographs, neither erythromycin, 400 mg. administered orally every six hours, nor tetracycline, 250 mg. given orally every six hours for periods of three to seven days, significantly affected wound healing. However, nitrofurazone applied topically had a demonstrably beneficial effect.

Administration of nitrofurazone alone does not provide spectacular results. However, when it is used in conjunction with other agents known to promote wound healing it possesses value.

Brain abscess—the insidious killer. M. H. Hicks and Harry S. Allen, Jr. (Florence) Amer Practit—13:381-383, June 1962.

The cases of six patients who had brain abscesses are presented, demonstrating the wide variety of circumstances under which these may develop and the wide diversity of symptoms. The need is shown for a high index of suspicion, and the inquisitive diligence that must be maintained by the practicing physician, if a diagnosis is to be made, and particularly if the diagnosis is to be made sufficiently early to afford the patient the likelihood of recovery from this serious illness.

Primary juvenile gout. Cheves McC. Smythe, M. D. and Joseph H. Cutchin, M. D. Amer J Med 32:799.

An unusual case of primary juvenile gout was studied at the Medical College Hospital. The disease resulted in dwarfism, first noted at eight months, then tophaceous gout at age 16 years, leading to invalidism because of secondary renal failure, and finally death in uremia at age 23. A definite bluish tint to the patient's serum was observed on many occasions for which no explanation was found. Hyperuricemia in the patient's mother and three of her siblings established the diagnosis as an inherited disorder of uric acid metabolism. It is postulated that this might have been "double dose" or homozygous gout. However, the course of this illness was so atypical that this might have been a previously unrecognized disorder of purine metabolism.

Editorials



SEASONS GREETINGS

AND

HAPPY NEW YEAR

SCALPEL

Among the outstanding but undesirable qualities of the medical profession of our state is an extraordinary apathy about its near future and eventual status.

No matter how busily engaged in his practice a physician may be, he can hardly plead ignorance of the threats to our medical way of life, nor can he safely sit back and depend on his fellow medical men to struggle with what they consider to be a grave danger to the practice of medicine in its present form. Numbers count, and money is essential in any effort to preserve our accepted system. A few conscientious and dedicated people cannot do the job alone, and the job must be done.

The charge of apathy in our midst is supported by the fact that the response to the SCALPEL movement has been disappointingly small. A few enthusiastic people have carried all the burden. It is time that all of us come to life and lend a hand in a situation which is posing imminent and permanent damage to our current medical philosophy and its application.

School Examinations

An article in the Anderson *Daily Mail* throws an odd light on the local attitude toward school health examinations. It has to do with the refusal of the County Board of Education to approve the system of examination of first graders by private physicians at the expense of their parents. The Board pointed out that the South Carolina law directs that not more than 10¢ shall be charged for each medical or dental examination and that this should be paid out of school funds. Furthermore the examinations are required by law.

The value of a 10¢ examination is invisible. Indeed the value of most routine examinations by school physicians is hard to see. They are usually perfunctory, by reason of time required, and it is impossible for a strange physician to examine properly a large number of children in a short space of time, since he has no way of going fully into their past histories and has necessarily inadequate knowledge of their peculiarities. Examination and certification by the private physician is immensely more valuable and need not be expensive. For those children who could not pay, the State might scrape together enough dimes to make up a reasonable fee for office examinations. There is nothing in the state code to forbid the validity of satisfactory examination by private physicians, although one section reads that the county and district Health Departments shall be expected to render service in the examination of school and pre-school children.

It is doubtful that the State Board of Health would approve of this attitude. Certainly the philosophy involved is very badly outdated.

Medicare

It is doubtful that the tendency to speak of the newly proposed plans for compulsory insurance as "medicare" can be checked. The term medicare has been applied for many years to those services rendered to the members of the armed forces and their families and is a well established and accepted program. It is unfortunate that its good name is being applied to something which is far less desirable.

Is Clinical Experience Sufficient To Determine A Child's Intelligence?

In these times of increasing interest in the situation of the handicapped child, and in the evaluation of his possibilities, more and more emphasis seems to be placed on the efforts of the psychologist to determine the child's potentials by means of certain well accepted testing methods.

Some of the older guard are somewhat inclined to question whether these elaborate, time consuming, and frequently expensive tests give information superior to that which an able pediatrician might extract by a very brief examination and estimate of the child's intellectual level. Some interesting comparisons have been made in an experiment in which a group of children were examined by both approaches. It was found that half of the pediatric estimates came within ten points of the more formal testing of intelligence by the psychologist and that two-thirds of the pediatric examinations came within fifteen points

of the psychologists's appraisal. In the overall estimate it was felt that there might be a twenty-five percent superiority in the results of fullfledged testing over the brief appraisals made by the physicians.

A combination of both methods seems to be the best approach, but this gets into the stage of elaborateness. What the examiner needs, whether he is psychologist or pediatrician, is some very simple, brief test which can classify a retarded child approximately as to his possibilities. After all, even a high I.Q. is not a guarantee of ability of anyone to meet situations in the best way.

MISCELLANY

Killers. Our concern about the possible harmful effects of the widespread use of toxic pesticides and herbicides has not been decreased after reading Miss Carson's book more fully. Obviously not everybody agrees with her thoughts, particularly as in the comment of the editor of one of our county bulletins. Obviously too somebody must be reading the *Journal* a long way off, because we have been the recipient of voluminous literature from — guess who — a manufacturer of pesticides. We are not convinced that this one has a satisfactory answer. Included with this "literature" was a copy of a book review entitled "Silence, Miss Carson." Not a very gentlemanly approach to the author — but then one does not necessarily need to be a gentleman to be a book reviewer. Certain arguments are advanced and it is pointed out that such obvious things as careful indoor residual spraying for the eradication of malaria-carrying mosquitoes can do no harm. No one will quarrel with that sort of example, but the broader aspects of the problem are still not considered.

We are not concerned with individual poisonings by ingestion such as are bound to occur in any situation in which parental carelessness allows a child to obtain toxic substances, whether they are pesticides or not. These are in the present state of things relatively inevitable. But the broad and promiscuous application of sprays to areas in which there is no greater problem than a temporary increase in harmless insects is another matter.

Joint Blood Council, Inc. Having successfully achieved its major goal of coordination, the Joint Blood Council, Inc. is being dissolved. This is a worthy step which some other organizations might emulate rather than to perpetuate themselves for the benefit of their employees.

Weekends. We find a sign of the times in a calendar put out by the publishers of *Life, Time* and *Sports Illustrated* which provides space for weekends only. No danger of Jack becoming a dull boy if he follows this schedule.

Resuscitation: Recent publications on the use of the closed chest method of cardiopulmonary resuscitation have promoted so much interest and application that the official bodies concerned with such matters have become somewhat alarmed about the overenthusiastic use of this valuable effort, and urge that special training be given to such persons as might be called upon to apply what might be a lifesaving procedure.

Nursing Homes: Encouragement is to be found in the many efforts being made to improve nursing homes and patient care in such homes. A recent meeting in Columbia afforded an opportunity to discuss such matters as rehabilitation of the hemiplegic patient, administration of drugs, licensing standards and the nurses responsibility.

Plan for Aged: Another answer to the Administration's misleading and inaccurate charges that people over 65 are entirely neglected lies in the new arrangement by the Blue Cross Plan whereby open enrollment periods for people 65 and older will be established before the year is out.



Portrait of Dr. Olin B. Chamberlain

On November 21, 1962, a portrait of Dr. Chamberlain was unveiled in the Department of Psychiatry of the Medical College of South Carolina, where it will remain as a memorial to him as the first professor of psychiatry in that institution.

The portrait is the gift of Dr. Chamberlain's numerous friends who subscribed to a fund for its painting and framing.

Dr. Chamberlain is a past president of the South Carolina Medical Association (1947-1948). Born in Charleston in 1892, he progressed from one scholastic distinction to another, graduating with first honors at the Medical College of South Carolina in 1918. He served hospital residencies at the Philadelphia General Hospital and at Roper Hospital, did general practice with emphasis on mental diseases for five years in Charleston, and then turned to psychiatry as a specialty. He spent some time in study at Queen's Square Hospital in London, and at Harvard University Medical School. He eventually became a full time member of the Medical College Faculty and was named as the first professor of psychiatry in 1946. He is a member of many scientific societies and organizations.

Previous to becoming professor of psychiatry he served more than three years in the Army, reaching the rank of colonel, and spending most of his time at Bushnell General Hospital in Utah.

Dr. Chamberlain has been very active in the affairs of organized medicine, and counts a host of friends over the state and elsewhere. He has always enjoyed the distinction of being an able, level headed, feet-on-the-ground psychiatrist, with a keen mind and sympathetic perception.

He has been incapacitated for several years, and is now a patient in the Medical College Hospital in Charleston.

TO MEMBERS OF
THE SOUTH CAROLINA MEDICAL ASSOCIATION

The Association expects early publication of

A HISTORY OF MEDICINE IN SOUTH CAROLINA, 1670-1825

by

Joseph I. Waring, M. D.
Editor of the *Journal* and
Chairman of the Committee on Historical Medicine

This will be a book of about 300 to 350 pages, bound in cloth, and illustrated. Each member of the Association is entitled to a copy of this book. The book has been sponsored by the Committee on Historical Medicine.

The Council of the Association has decided that the best way in which this book might be distributed is by request, and therefore **it will be sent only to those members who send in the request slip below.** The book will be sent to you without cost. Applications must be received by January 15 in order to determine the number of books to be printed. After the initial distribution of the books, members of the Association may purchase extra copies at $5.00. It is expected that this book may sell for more in the book shops.

Mail to: J. I. Waring, M. D., Historical Library
Medical College of S. C., 16 Lucas St., Charleston, S. C.

Please send my copy of the *History of Medicine in South Carolina* to:

_____
Name

_____
Street Address

_____
City State

Public Relations

SUPPORTER OF KING-ANDERSON BILL RE-ELECTED TO SENATE

In the light of the recent election returns in South Carolina *and* around the nation, it seems timely to reprint a checklist of ways physicians may warn the people against the certain threat of more "medicare" legislation.

Letter Writing to Congressmen:

A. Obtain current attitude of Congressmen in each district through brief visit by physician who is friend of Congressmen. On basis of attitude write and urge your friends to write their views.

1. If Congressman is for Kerr-Mills, let him know you appreciate his stand and encourage his continued support. Offer him your help and keep him alerted to any new arguments supporting Kerr-Mills.

2. If he is for "medicare," don't condemn him. You'll only offend him. Instead try to reason with him, pointing out clear and logical objections to "medicare" legislation. If you have friends in the 65-and-over group who oppose this type of bill urge them to write and explain their stand. Point out that centralized bills, such as King-Anderson, would be administered from Washington, thus depriving him—and other state leaders of the right to administer and distribute state funds. This usurps the rightful privileges of a state's elected leaders. It weakens the image these leaders make on their constituents and it weakens the structure of state government.

3. Appoint a letterwriting committee to function through the county society. This committee would request members to write and to ask their friends to write. As a follow up blind copies of these letters would be returned to the society committee for records and progress reports.

4. Alert your patients to the need for an active flow of letters to Washington. Outline the disadvantages to them — as individuals — if "medicare" legislation is passed.

Resolutions to Congressmen and Senators from:

1. County Farm Bureau
2. Civic Clubs
3. Hospitals

These resolutions should be simple and to the point . . . what organization . . . where located . . . membership . .. stand or resolution taken. An impressive amount of support may be gained by appointing a committee to seek the support of these and similar groups . . . in each case giving them specific reasons why "medicare" is unfavorable to them.

Visits to heads of large local employee groups.

1. Emphasize what ½% tax increase would mean to their total organization. ½% of salary up to $4800.00 plus number of employees.
2. Stress fact that central federal programs siphon off earnings from state.

Quarterly follow-up calls on Congressmen

1. Check his reactions.
2. If previously unfavorable, see if he has altered his stand.
3. Encourage his stand when his reaction is favorable and let him know you appreciate his support.

Sidelights from elsewhere

Savannah Morning News, Oct. 25, 1962

"A new survey of the economic condition of American families made by the Michigan Survey Center indicates that forcing higher payroll taxes on the nation's workers to buy health care for the aged would be an injustice. The survey shows the aged owning considerably more assets and owing fewer debts than younger families, 96 percent of the aged did not owe a penny to a hospital, physician or dentist and did not feel that paying for medical care is a pressing problem."

KERR-MILLS IN SOUTH CAROLINA

The following figures were released by Dr. Arthur B. Rivers, Director, State Welfare Department, Columbia in November.

3,454—received hospital treatment during fiscal year 1961-62

88—received additional convalescent and nursing home care

1,867—received out patient treatment

$868,452.00—total cost of program

Predicted expenditures—Dr. Rivers indicates services and expenditures will be doubled during the current fiscal year as more people become familiar with the program. He announced liberalization of eligibility requirements, which were feasible because of the successful first-year operation of the program. Allowable annual income has been raised from $1000 to $1200 for single persons, and from $1800 to $2000 for couples. An interesting side note — *less than half of the 160,000 South Carolinians over 65 would be covered under a medicare program financed through increased social security.*

And In Other Areas

Wilmington, N. C. Morning Star, Oct. 29, 1962

"The North Carolina State Grange Saturday made a complete turn around and came out in support of medicare through the Kerr-Mills Bill. The group announced it now supported the medical care for the aged proposals of the bill, "instead of the plan proposed by the Social Security Administration."

News

Dr. Truluck Honored For Long Service

Dr. George Madison Truluck, one of Orangeburg's most outstanding citizens, was honored recently by the Edisto Medical Society and the S. C. Medical Association in recognition of his half-century of active practice as a physician.

Dr. L. P. Thackston, Sr., who was chosen by the local society to acknowledge the distinguished physician's accomplishments, pointed out that such extended service in the medical field was not common.

Dr. J. H. Gressette, president of the state Association, added to Dr. Thackston's comment by saying, "the 50-year mark is the one we all hope to attain." The honoree received the announcement that he would soon have the Medical Association's coveted 50-year service pin and also received a $65 gift certificate for a sport coat from the members of the local organization.

Dr. Thackston recalled having a conversation with the honorees' 18th Infantry commanding officer after World War I.

"As a member of the famed 'Old Redeye Division,'" Dr. Thackston said, "George once was overcome by gas and could hardly breathe but he still tended to the wounded." For continued medical service of this nature, he was honored "as a real man . . . one that all of us are proud of."

Dr. Truluck received the highest recognition to which a South Carolina physician can aspire when he was elected to the state Association's presidency in 1941. He has served as a counselor to that body for the past 12 years.

A graduate of Clemson College and the Medical College at Charleston he completed his graduate work at the Manhattan Eye, Ear, Nose and Throat Hospital and practiced in Marion, S. C., before coming to Orangeburg.

He is a past president of the Orangeburg American Legion post, a staff member of the Orangeburg Regional Hospital, an elder at the First Presbyterian Church, and has been chairman of the local draft board for the past 15 years.

Medical Self-Help Classes

Two more classes in Medical Self-Help, sponsored by Rock Hill Civil Defense and the American Medical Association, have been formed. The classes, which began in October, were open to both men and women.

Coastal Medical Society

The Coastal Medical Society met October 18 in Charleston. Dr. Douglas C. Appleby, guest speaker, addressed the meeting on "Resection of the Colon for Carcinoma."

Dr. Hopkins Joins Dr. Dunn in Practice in Columbia

Dr. Edward D. Hopkins, Jr. has recently returned to Columbia and is associated in practice with Dr. Shepard N. Dunn.

Their practice is limited to the specialty of eye surgery and diseases of the eye.

Dr. Hopkins is a graduate of The Citadel and the Medical College of South Carolina. He interned at William Beaumont Army Hospital in El Paso, Texas, and spent two years as an Army medical officer stationed in Germany.

He completed his residency training in ophthalmology at Tulane University School of Medicine in New Orleans, La.

Dr. Coggeshall Speaks

Dr. B. E. Coggeshall of Cheraw was guest speaker at the fall meeting of the Chesterfield Home Demonstration Council. He addressed the meeting on cancer.

Three Local Men Named To State Cancer Board

Three Charleston men have been named to the board of directors of the South Carolina Division of the American Cancer Society.

They are Dr. H. R. Pratt-Thomas, president of the Medical College of South Carolina; Dr. George H. A. Clowes, department of surgery at the medical college; and Dr. Jack Rosen, president of the S. C. Dental Association.

The announcement was made during the state Cancer Society's fall meeting in Columbia.

During the meeting some 300 volunteers heard Dr. Cheves Smythe, dean of the school of medicine at the medical college, outline the progress in professional education and research, with emphasis on cancer control.

Medical Men Hear Smythe

Dr. Cheves M. Smythe, dean and associate professor of medicine at the Medical College of South Carolina, addressed a meeting of the Greenville County Medical Society in October.

Dr. Smythe spoke on "Peritoneal Dialysis, Technique and Indication."

Medical College Addition Dedicated November 21

Official dedication of the $548,000 tenth-floor addition to the Medical College Hospital took place November 21.

Toumey Hospital Wing To Open In Sumter

The new wing to the Toumey Hospital, named the O'Donnell Building, will be completed in December and placed in operation the following month. The addition to the hospital was constructed at a cost of $673,878.

The four-story building has a floor space of 27,000 square feet with a brick and stone trim exterior. It provides space for 92 beds, giving the hospital a total 204-bed capacity.

F.A.C.S.

Two South Carolinians, Dr. William J. Goudelock of Easley anl Dr. William F. Dukes of Orangeburg, were among approximately 1,100 surgeons who were inducted as new Fellows of the American College of Surgeons October 19 at Atlantic City. The inductions took place in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons.

"Trick or Treat" for Heart and Lung Clinic

The Sertoma Sunrisers Club of Greenville held a Halloween "Trick or Treat" Candy sale to aid the heart and lung clinic of the Greenville General Hospital. The proceeds of the sale were for the purchase of equipment for the cardio-pulmonary clinic.

New Doctor Comes to Ridge Spring

Several years of searching and advertising for a doctor has finally paid off for the Ridge Spring-Monetta Jaycees. This project was climaxed when Dr. and Mrs. I. A. Ceips and family moved into the community. Dr. Ceips was scheduled to open his office in Ridge Spring for practice on October 8. The docaor and his wife are natives of the country of Latvia. They have been in the United States about 12 years, approximately eight of which Dr. Ceips spent as a doctor in the U. S. Army.

Dr. Whitten Is Ready To Retire

Dr. B. O. Whitten, long-time superintendent of the state-operated Whitten Village school for mentally retarded children and adults at Clinton has indicated he is ready to retire.

The 78-year-old veteran worker with the retarded said "I've been ready for retirement if the proper arrangements can be made."

He said he has been seeking the "right choice" for some time. There are one or two people in mind.

Doctor Whitten said he has no objection "to letting people know I'm retiring." But he said he could be available "for any service in any capacity if I should retire and if it appears to be any benefit to the Village."

"I don't want anybody to feel that my shadow is in the way, so to speak," he said, adding that he would want "to strengthen my successor."

Asked how soon he expected his retirement, he answerd that he didn't know.

"I have been working here a long time and perhaps I do need to retire, but until we get some of the problems worked out," he said, "it is a right difficult decision to locate what the board thinks to be the right choice."

Dr. Collins Wins Fellowship

Dr. Arthur R. Collins, Jr., 218 South Mountain Street in Union, S. C. has been awarded a Wyeth Laboratories residency fellowship in pediatrics, it was announced by Dr. Philip S. Barba, chairman of the selection committee and past president of the American Academy of Pediatrics.

Dr. Collins served his internship at the Medical College of South Carolina, Charleston, and is taking his residency there. He also received his medical training at this same medical college.

Dr. Smith To Attend Seminar At Duke

Dr. Dwight H. Smith, who is one of four Anderson County physicians designated as aviation medical examiners for the Federal Aviation Agency, is scheduled to attend a seminar during the first week in November at Duke University Medical School. The medical examiners attend these seminars every three years.

Dr. Bowers Gets Florida Post

Dr. James Bowers, young Walhalla physician, has been appointed to the Student Health Service staff at Florida State University in Tallahassee.

In his sixth year of practice, Dr. Bowers is a native of Oconee county and is a graduate of the Medical College at Charleston.

Training in Psychiatry

The National Institute of Mental Health has instituted a program of tuition support for general practitioners who wish to make a career in psychiatry. This program originally was intended to attract general practitioners to psychiatry in order to alleviate the acute shortage in this field. It was deemed necessary to make the stipend attractive enough that the general practitioner would not have to make an undue financial sacrifice for this change in career. The Psychiatric Department of the Medical College of South Carolina is receiving applications from general practitioners to utilize this program. At the present time Dr. Donald Cummings is using this program to complete his residency in psychiatry. It is anticipated that three such residencies will be available as of July 1, 1963.

At the same time, The National Institutes of Mental Health recognized that there were physicians interested in a further training in psychiatry who did not wish to make a career of psychiatry. They have instituted a program in which the physician can pursue six months intensive study and resume his

previous practice aided by this additional knowledge. Stipend funds have been provided for this program.

Seminars in general psychiatry, child psychiatry, and psychosomatic medicine will be initiated this year for physicians who wish to study only two hours per week while they continue their practice. The first such seminar in child psychiatry has begun under the direction of Dr. R. R. Mellette. The quota for this class has already been completed. A second seminar will begin approximately January 1, 1963, in the Columbia area and several openings are still available. Interested physicians should direct inquiries to the Department of Psychiatry, Medical College of South Carolina, Charleston, South Carolina.

Self Memorial Opens New Wing

Self Memorial Hospital opened the third floor of its new wing in October, adding 33 beds to the hospital capacity, which will make a total of 212 beds.

A. P. Nisbet, hospital administrator says the second floor of the new wing is scheduled to be completed in January. It will be exactly like the third floor.

When the second floor is ready for occupancy, present patient rooms on the fifth floor will be given up and renovation started in that section.

A complete new surgery unit is being prepared on the fifth floor of the new wing. It is scheduled to be ready in March. After the new surgery unit is in use, the former operating rooms on the fifth floor of the main building will be converted into a central sterile supply department.

Dr. Moyd Heads Medical Society

The Darlington County Medical Society has elected officers for the coming year. They will be headed by Dr. Pickens K. Moyd of Hartsville as president.

Other officers elected are as follows:

Dr. Joe S. Matthews, III, vice-president; Dr. John M. Wilson, secretary-treasurer; Dr. Barney Timmons, delegate; Dr. Jack Perry, alternate; Dr. George Timmons, Dr. J. C. Parke and Dr. C. E. Aimar, censors.

Dr. Wittson Appointed

The Camden-born physician, Cecil L. Wittson, Chairman, Department of Neurology and Psychiatry, University of Nebraska College of Medicine, Omaha, Nebraska, has been appointed by USPHS Surgeon General Luther L. Terry to serve a four-year term on the National Advisory Mental Health Council, beginning October 1, 1962. As a member of the National Advisory Mental Health Council, Dr. Wittson will advise and make recommendations to the Surgeon General regarding research and training programs sponsored by the National Institute of Mental Health in Bethesda, Maryland. Dr. Wittson received his M. D. degree from the Medical College of South Carolina in 1931.

Spartanburg Hospital Agrees On Contract For Doctors

Spartanburg General Hospital's Board of Trustees Wednesday approved a contract with two hospital pathologists and finally reduced a nine-month-old agreement with radiologists to writing.

The contracts allow the doctors to make about $25,000 a year each, the same amount they were making before the contracts were signed, according to Board member R. T. Thomoson, Jr.

The pathologists, Drs. M. F. Patton and W. S. Cheek said they felt the contract was "reasonable."

Clinton Hospital Opens

The Clinton Hospital District's Bailey Memorial Hospital opened Monday, October 1, for the reception of patients. The opening followed dedication ceremonies during which an estimated 2,000 to 3,000 persons toured the 52-bed $1,200,000 facility. Two small local institutions, Hays Hospital and Blalock Clinic, which have served the community for a number of years, will close. Joanna Hospital closed several months ago.

Area Physicians Named To Posts

Four Spartanburg area physicians were named to official positions in the South Carolina Academy of General Practice at the 14th annual scientific session held in Charleston this week.

Dr. Harold P. Hope of Union was elected vice president of the Academy and Dr. John W. Blanton of Chesnee, treasurer.

Dr. George Duncan of Spartanburg was named to the board of directors and Dr. George Price also of Spartanburg, delegate to the 1963 national convention of the academy.

Drs. Ruff and Dixon Are Hosts To Norway Youths In Anderson

Dr. James M. Ruff and Dr. James M. Dixon, Jr., doctor partners of Anderson, are playing hosts this year to two Norwegian teenagers they met during a summer tour a year ago. The two youths, who were hitchhiking and given a ride by the doctors in Denmark, are Harold Novik and Knut Mjavatn, both 16, from Oslo, Norway. They are now settling into the routine of Hanna High School and busy Americans living in Anderson, as guests in the Dixon home.

After comparing transcripts with their former school it was found that Norwegian students generally are far advanced academically over their American counterparts. They have had two years of German, four years of French and four years of English, as required in Norway, where schools are operated six days a week, 10 months a year. The boys plan to become electrical engineers.

Thus far, biggest impact of America on them has been the number of new automobiles.

Application For Rehabilitation Center Approved

The initial application for the Easter Seal Rehabilitation Center in Aiken has been approved by the State Board of Health, the U. S. Public Health Service, and the Office of Rehabilitation.

This facility has been estimated to cost $191,873.50 with a federal share of $126,915.67.

Dr. Boulware Is Assistant In Disease Control

Dr. John H. Boulware has been employed by the South Carolina State Board of Health as an assistant to the Director of the Division of Disease Control. He will assist Dr. McDaniel in chronic diseases and epidemiology.

A native of Kershaw County, he attended the schools in Camden, the University of South Carolina and Washington University in St. Louis, and he received the M. D. degree from the Medical College of South Carolina.

He served his internship and a one-year residency in surgery at the McLeod Infirmary in Florence and spent one year at the American Hospital in Paris. He served in the Air Force in Japan during the Korean War and has done private practice in Atlanta. He has completed two years of public health residency in Virginia where he was assigned to the Danville and Pittsylvania-Halifax County Health Department. He was in private practice in Darlington before coming with the South Carolina State Board of Health.

He lives at 2230 Terrace Way in Columbia.

One Million Set Aside For Laboratory Building

The sum of $1 million, if so much be needed, to pay part of the cost of constructing a State Board of Health Laboratory Building was set aside out of the 1962-63 Hill-Burton allotment to this State by the Executive Committee on September 12. This was done upon the advice and consent of the Hospital Advisory Council which met on September 6.

This propect will be sponsored by the Budget and Control Board. The architectural firm of Baker & Gill in Florence has been employed to prepare plans and specifications.

Liefcort Illegal

Sufferers of arthritis were warned by the Food and Drug Administration that the drug Liefcort, which is being obtained from Canada, is eminently dangerous and may not legally be imported into the United States.

Liefcort contains potent hormones including estradiol, prednisone and testosterone. FDA analysis showed the product contains 10 times the therapeutic dose of estradiol. According to the FDA Bureau of Medicine the hormones are capable of causing severe toxic effects.

W. B. Saunders Company Announces $15,000 Writing Fellowship Grant

To mark its 75th Anniversary in 1963, The W. B. Saunders Company, medical and scientific publishers, are making available $15,000 for an unusual medical writing award. A distinguished committee will select the grantee.

The purpose of this grant is to provide financially for a year's leave of absence for a distinguished investigator who:

(1) Has been doing fruitful and significantly important biochemical laboratory research over the past several years.

(2) Would like to have time for thought and for preparation of his work in monographic form.

The recipient of the award will not have to agree to publish his monograph with the Saunders Comany and will be free to write, instead of a book, a series of journal articles reviewing his research.

Speaking of Syphilis

South Carolina public health personnel will be interested to learn that Dr. J. Richard Allison, Jr., of Columbia has recently been honored through appointment by the U. S. Public Health Service as Special Venereal Disease Consultant in connection with the national syphilis control program. In this capacity he is now available for speaking engagements to professional groups.

Dr. Allison is in the private practice of dermatology and syphilology and is attending physician at the Columbia, Baptist, and Providence Hospitals in Columbia. He is a consultant to the U. S. Veterans Administration Hospital in Columbia, to the U. S. Air Force at Shaw Field, to the U. S. Army at Fort Jackson, and is consultant in charge of the Richland County Venereal Disease Clinic in Columbia.

He received an A. B. degree from the University of North Carolina in 1947 and was graduated from the Medical College of South Carolina in 1951.

The following procedure should be followed for requesting guest speakers through the U. S. Public Health Service:

Whenever practicable, choose speakers from your geographic area.

Indicate in addition to your first choice at least two alternates.

Provide basic information on type and size of audience, including any background information that would help the speaker in his presentation.

Because most of these speakers normally have very heavy schedules, allow as much time as possible, preferably a minimum of six weeks.

Since expenses in providing these speakers are defrayed by the Venereal Disease Branch, CDC, speaking commitments can be made only through the VD Branch, and requestors are asked not to approach speakers directly, as this will only delay final arrangements.

Send requests to Venereal Disease Control Section, S. C. State Board of Health.

Requests will then be forwarded to the Communicable Disease Center in Atlanta for final authorization.

Mental Health Association Reports Growth

The South Carolina Mental Health Association, a Division of the National Association for Mental Health, reports that there are now 24 chapters in South Carolina and that more are in the process of organization. When SCMHA came into existence in 1954 there were only 4 active county mental health chapters in the state.

Genetics and Heart Symposium

A 2½-day symposium on Genetics and Heart Disease, sponsored by the Heart Association of Southeastern Pennsylvania, will be held January 24-26, 1963, at the Hotel Sheraton, Philadelphia. For a copy of the program and an advance registration application form, write: Albert N. Brest, M. D., Heart Association of Southeastern Pennsylvania, 318 South 19th St., Philadelphia 3.

Dr. Stacy Joins U.S. P.H.S.

Dr. William K. Stacy, Jr., of Anderson, was recently commissioned as senior assistant surgeon in the United States Public Health Service. He left a short time ago for Denver, Colo., where he will serve with the Colorado Health Service in cancer control.

Medical College Alumni Meet

The National Alumni Meeting of the Medical College of South Carolina was held November 13 during the Southern Medical Association Meeting in Miami. Dr. Tom Pitts, Dr. Kenneth M. Lynch and Dr. H. R. Pratt-Thomas were featured on the program. Dr. Jack Norris of Atlanta continues to be the enthusiastic promoter of this meeting.

Dr. Kinney Heads Seal Sale

Dr. C. A. Kinney has accepted the chairmanship of the annual Christmas Seal Sale for Marlboro County. Dr. Kinney was considered an excellent choice for this post, having at one time served as consulting surgeon for the Florence-Darlington Tuberculosis Sanatorium.

Nursing Homes

The Executive Committee of the SCANH has met with Dr. Arthur Rivers, Director of the State Department of Public Welfare, several times in the past two and a half years. We discussed the inequitable and inadequate payments to Nursing Homes for the care of recipients of Welfare controlled benefits. Dr. Rivers assured Nursing Homes that when he had some method of determining a good home from a poor home, his Department would be in a position to consider more adequate financial reimbursement. The Classification Program was developed to identify the types of services rendered in different homes. When we can present Dr. Rivers a list of homes which have been reviewed and identified, and present actual cost of operation on each type, he will be in a position to develop and adjust payment rates for his clients who live in Nursing Homes. As soon as Nursing Home Administrators in this State realize that the only way they are going to get more adequate payment is to stand up and prove themselves for what they really are, then and only then, will they receive more money for services rendered to Welfare recipients. Your entitlement to more adequate payment now rests entirely in your hands. What will you do for yourself?

News Letter—S. C. Assoc. of Nursing Homes

SCALPEL

APPLICATION FOR MEMBERSHIP

South Carolina Alliance for Liberty, Political Education and Life
110 South Calhoun Street, Greenville, South Carolina

Name_____
First Middle Last

Office Address_____
Street City State

Residence Address_____

Member of_____ Medical Society
(county society or equivalent) Medical Auxiliary_____
State

Date of Application_____, 19_____

Signed_____

Editor's note: In the June issue of this *Journal* there appeared an article from the Markle Foundation which evoked some thought about the over-emphasis on research in medical education. The paper below presents the other side of the question and is reprinted at the request of one of the professors of the Medical College of South Carolina and by permission of the author and of the editor of the *British Medical Journal.*

THE VALUE OF PARTICIPATION IN RESEARCH AS A COMPONENT IN THE EDUCATION OF DOCTORS FOR THE MEDICAL, GRADUATE, AND POSTGRADUATE STUDENT*

VICTOR JOHNSON, M.D., Ph.D., Sc.D.

Director, Mayo Foundation for Medical Education and Research; Professor of Physiology, University of Minnesota Graduate School, Rochester, Minnesota, U. S. A.

There is no need to document the value of medical research as a major factor in the constantly improving well-being of mankind. It could be convincingly contended that our knowledge of health and our control of disease have progressed farther in the last 50 or 60 years than in all the preceding countless ages of man.

Further, it is unnecessary to declare the value of participation in research for a medical student who anticipates either a career of full-time investigation or part-time clinical research supplementing the practice of medicine. The methods and tools of research, the nature and conduct of investigation, must be learned early. A physician who has done no investigation by the time he has finished his postgraduate residency training is unlikely to make significant contributions to research in his subsequent career.

It is self-evident that research must continue to increase our understanding of man in health and disease, and also that experience and training in scientific investigation are essential at an early stage in the education of the physician who intends to continue to carry on research. This presentation is concerned rather with the value of participation in research as part of the experience of a medical student who may not again work in a research laboratory, who has no intention of conducting further clinical investigation, or who will never write another scientific paper. Some training in research can contribute enormously to the education of such a physician, engaged entirely in clinical responsibilities, as is necessarily the case with most physicians.

Evaluation of Research Reports

Past research experience by a physician who is now fully engaged in clinical practice sharpens his judgment and enhances his evaluation of the research of others. "Medicine, a lifelong study," requires the physician to keep abreast by reading the journals and listening to scientific papers. Research necessitates a struggle with data collected, requires a sifting and sorting of experimental results, insists upon a recognition of deficiencies in the supporting evidence, compels the reaching of conservative conclusions warranted by the objective findings. Experience in research warns against the pitfalls of inadequate numbers of observations, faulty controls, inaccurate measurements, the intrusion of chance, the inherent variability of biological material. Engagement in research enhances the physician's judgment of conclusions reached in medical papers he reads, sensitizes him to inadequacies of evidence, increases his wariness of exaggerated claims, tempers his acceptance of enthusiastic predictions.

Difficulty of Discovery

Research has been called "a way of making Nature talk." But Nature guards her secrets with intense jealousy and is loath to speak. Research reveals the painful difficulty of discovery.

To the layman, who reads only the newspaper or popular magazine accounts of discovery, the pathway is easy. To the more sophisticated, such as a medical student or practising physician, somewhat familiar with research literature, the difficulty of making a contribution to knowledge becomes more apparent. But it is only the student or physician who has actually participated in research himself who is completely aware of the tremendous effort and patient toil which are exacted of an investigator who establishes even a very little new fact or a causal relationship.

A celebrated exception to this axiom was the discovery of vagus material, by Otto Loewi. He recounted that he had an idea one night, in bed, and went to his laboratory next morning to test his thought. In this instance, only a day elapsed between the idea and the demonstration. New principles of broad physiological application emerged: not only the concept of neurohumoralism but eventually also the theory of chemical transmission of nerve impulses across synapses.

Much more characteristic of the unhasty pace of research discovery is the story of insulin, with the long and laboured span of three decades between the experimental production of diabetes in dogs and the beginnings of its control in man. Years of frustration were the only rewards of investigators probing this most jealously guarded secret of nature. The dual function of the pancreas, as a digestive and an endocrine gland, the concept of hormonal secretion, the idea of replacement therapy, the enzymatic destruction of islet secretions in crude pancreatic extracts, the correct pH to preserve the islet-tissue hormone, the embryonic history of the pancreas (noted and utilized by Banting), the purification of the embryonic extracts of islet tissue free from digestive secretions, and, finally, the therapeutically successful injection of these extracts into diabetic dogs, took years and years and years of labour and failure and frustration.

*An address given to the Second World Conference on Medical Education, Chicago, 1959.

The struggle for insulin soundly documents that hard lesson of research experience, the difficulty of discovery.

Pursuit of a Scientific Hobby

Even though a physician may do no research or engage in a limited specialty such as cardiology, a past research experience may provide a rewarding hobby or special interest to be followed at least in the literature and perhaps also at scientific meetings.

The postgraduate resident physician who spends only three to six months in a cardiac catheterization laboratory might be prompted to follow subsequent findings in this field with considerable gratification. He will observe with special appreciation the latest developments in artificial blood circulation, extracorporeal aeration of blood, refrigeration, control of cardiac arrest, electrical pacemakers, intracardiac prostheses, repair of valves and septal defects—the many discoveries to come in the control of congenital and acquired cardiac defects.

Alertness for the Unexpected

Research develops an alertness to the apparently inconsequential. In carrying out any research project it soon becomes apparent that it is essential to be forever on the alert for an unexpected observation sometimes seeming almost to be an accidental occurrence.

Each such occasion must be given due weight. The incidental observations may prove to be far more important than the original goal sought in the experiment. The magnitude of Fleming's discovery was not at all apparent from his simple description of an experimental accident of vast moment: "While working with staphylococcus variants a number of culture-plates were set aside on the laboratory bench and examined from time to time. In the examinations these plates were necessarily exposed to the air and they became contaminated with various micro-organisms. It was noticed that around a large colony of the contaminating mould the staphylococcus colonies became transparent and were obviously undergoing . . . [destruction]."

This kind of alertness to apparently insignificant detail, not directly in the pathway of the moment's reflection or not immediately integrated into the experimental context, has yielded many a discovery. For lack of this sensitivity how many important discoveries were missed: the vector of transmission of the poliomyelitis virus, the arresting of mitosis in cancer cells, the dissolving of a blood clot in a coronary vessel.

Clinicians who rise above the common lot have, perhaps in many instances through research experience, similarly become allergic to the minute, the obscure, the incongruent. A few tiny petechiae may point to a subacute bacterial endocarditis in an obscure complex of signs and symptoms. A 30-year history of healed pulmonary tuberculosis might provide the diagnostic clue to a painful palpable mass in the pelvis.

Collaboration in Clinical Practice

Research provides lessons in team-work. Little modern research of consequence is carried on by the lone investigator. More commonly in evidence is the combined effort of experts in several disciplines. Studies on poliomyelitis vaccine necessitate collaboration between the bacteriologist, neurologist, internist, statistician, epidemiologist, biochemist, pathologist, and others as well.

Team-work in clinical practice is equally necessary, particularly in dealing with complicated problems. In a modern clinic it is not unusual for experts from half a dozen or more clinical specialties to collaborate in arriving at a diagnosis and determining management.

Who does not learn, perhaps in an experimental laboratory, this lesson of team-work in the practice of medicine and the employment of consultations by a collaborating group will be much less than a good physician.

Persistent Routine

Research fosters a respect for persistent routine. Inspiration and glamour are not prominent in the continuing plodding which is demanded. The researcher patiently repeats the experiment again and again, week upon week, changing the procedure, perfecting the technique, analysing the failures, month after month doggedly pursuing the goal with no assurance of reaching it. There is an abundance of routine and boredom demanding inordinate tenacity to continue the venture. What thousands of dull red-blood-cell counts for long hours of many months provided the evidence to Whipple that liver accelerates red-blood-cell production in anaemic dogs! How many frog nerve muscle preparations were carefully dissected by Helmholtz before he determined the speed of the nerve impulse!

Everyone who would contribute importantly to the world's work must learn this lesson of persistence in routine. The President of the United States must spend a lot of time writing his name. The concert pianist must practise alone for hours on end. The physician must percuss the heart borders of the hypertensive patient again and again. The medical student must laboriously repeat white-blood-cell counts on the patient with an infection.

The rewards of research or of medical practice demand countless unglorious hours of stubborn work as a routine, as might be found in the performance of many a less pretentious task than medicine.

Highway of Discovery

Research provides knowledge and familiarity with one of the highways of discovery. The study and reading essential in carrying out a research project, determining what has gone before in this area, and what yet needs to be done, are as different from the more casual reading of such material as actually travelling a countryside is different from reading a highway map. The gratification of such an excursion is intensified by the ultimate arrival at the end of the charted road where exploration into the unknown occurs.

The discovery is usually very modest. Often it is a negative finding, the posting of a warning on a

dead-end street. Yet it is a discovery, new knowledge, light into the darkness, a penetration beyond the frontier. Discovery, great or small, of what was never known before is an adventure to be cherished, an experience likely to colour a physician's entire outlook on his work. The physician who is imbued with the spirit of investigation, augmented by research experience, will be a little more persistent in his diagnostic searchings, in his therapeutic efforts, or in his self-evaluation.

Summary

Experience in research as a medical or graduate student may stimulate a continuation of some investigation throughout life. Even if the physician does no research after his formal education, his earlier experience in investigation will prove of tremendous value, because research sharpens the physician's judgments of the scientific pronouncements of others, it reveals the painful difficulty of discovery, it stimulates the pursuit of a scientific hobby. Research promotes an awareness of unobtrusive "accidental" phenomena which may be of great importance, it provides lessons in team-work, it fosters a respect for persistent routine.

Research acquaints the investigator and physician with one of the highways of discovery leading into the unknown.

British M.J. 2:332-334, Sept 5, 1959

Death

DR. PAUL SASSER

Dr. Paul Earl Sasser, 60, prominent physician of 611 Elm St., Conway died at his home November 9.

Dr. Sasser was born in the Bayboro section of Horry County. He was graduated from the Conway Schools, attended pre-med school at the University of South Carolina and was graduated from the Medical College of South Carolina in 1928.

He practiced in Conway until retirement on Jan. 1, 1962 at that time he was made an honorary member of the staff of the Conway hospital. He was a member of the Horry County Medical Association, and the South Carolina Medical Association. He was a member, trustee, and past deacon of the Kingston Presbyterian Church. He was a member of the board of directors of the Conway National Bank, the Peoples Savings and Loan Association, and a past member of the Conway Lions Club.

APT WORDS AND TROUBLED MINDS

By Dr. K. D. Devine

Apt words have power to suage the tumours of a troubled mind.—Milton: Samson Agonistes

The youthful surgeon, explaining to his patient the particular condition at hand, may use words and phrases which mean much to another surgeon but which only confuse and perhaps frighten the patient. Very likely such an action is only to be expected because for perhaps a decade in the competitive world of the medical school, internship, and residency the young man has been trying to impress others of his kind with his ability to use and understand weighty words and special symbols. Inevitably, except in rare instances, he goes out into the realities of medical practice where he believes he must impress the patient and his family with a conviction of his ability and skill.

Deserve Answers

Patients of our era have taken on some sophistication in medical matters, and they are no longer impressed by the "treat 'em rough and tell 'em nothing" surgeon. The public expects to ask some questions and deserves to receive some answers when questions of health and medicine are imminent. Now, it is always more impressive when a man possesses the ability to answer questions before they are asked. Explanations and answers given to patients should not be encumbered with words which convey nothing but trouble and foreboding. Simple, everyday phrases and words which at other times or under other circumstances might seem unlettered or rough can elicit a nod or a smile of understanding—a smile of confidence and faith.

Almost anyone who has had the pleasure of reading to children has encountered A. A. Milne's adventures of Winnie-the-Pooh. It was this lovable little creature who said unashamedly, "I am a Bear of Very Little Brain, and long words Bother me." Thus it is, I am sure, with patients not schooled in medicine.

Words such as "windpipe," "voice box," "jawbone," "saliva" or even "spit gland," and "large bowel" are better than "trachea," "larynx," "mandible," "parotid gland" and "colon." Many times I have heard a patient mispronounce the word "biopsy" in such circumstances that I realized that he did not know just what it means. It is better to say that a piece of flesh, or whatever the tissue in question is, will be removed so that it can be looked at under the microscope by a special doctor who can tell by such an examination what kind of trouble is at hand than it is to say, "We will do a biopsy and have it analyzed by a pathologist."

Simple Words

Instead of saying to the patient, "You have a tumor in your neck which may be serious and you might need a big operation," it is better to say, "There is a lump in your neck and you have come

to the doctor to find out what it means. It is as though I had put an orange on the table here and covered it with blankets and asked you to come in and feel through the blankets and tell me exactly what was on the table. You could describe it as being 'round' and 'soft' and 'not attached to the table' and you might guess it to be an orange, tomato or apple. The only way to be certain is to take off the blankets. And so it is with the lump in your neck. I could feel through the skin of your neck and give you a guess, but you don't want a guess; you want to know. So it must be removed and examined with the microscope, and the treatment might require removal of other things in your neck."

Satisfy Patient

I suspect that every successful surgeon, to deal with questions about proposed operations, has developed some favorite phrases, stories and similies which quickly answer many questions and which satisfy the patient and impart confidence in the surgeon. The sooner the young surgeon develops his own simple way of explaining problems to his patients, the easier his lot will be and the more satisfying his practice will become.

The late Gordon B. New in such an incident was a master at what he called "setting the stage." That was his phrase for preparation of the patient and family for the news that an operation was required so that they would have some understanding of what lay ahead. All too often the patient, who has no knowledge of what surgical treatment can and cannot accomplish, expects more from an operation than is reasonable, and for this reason it is better to come to an understanding on this point before and not after the operation.

If the young surgeon, trained to the nth degree, full of confidence and extremely competent, looks about him and is puzzled and perhaps angry at the success of the busy and, to his way of thinking, incompetent or less adequately trained surgeon, he should remember that "there is more to it than just the cutting."

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ON JUDGMENTS OF THE INDUSTRIAL COMMISSION

IRWIN GRIER LINTON, M. D.
CHARLESTON, S. C.

Our state and counties spend large amounts of money to attract and establish industry here. After the many advantages of locating in the area have been recognized, and after much planning and promising a factory is put into operation. All is well, until after the speeches and picnic of opening day are over and plant operations starts—then an employee is injured.

One day a droplet of molten metal popped into the external auditory canal of an employee. There was some injury to the canal wall and to the tympanic membrane. He was treated by a capable EENT man, and after many months of patient and intensive therapy he recovered. The defect in the ear drum closed and the external canal healed. During the treatment the canal was usually blocked by a cotton plug. After recovery the man claimed loss of hearing. His physician reported about 90 to 95% loss of hearing in one ear. This was established by checking one ear at a time with a sound source not visible to the patient. An audiologist was asked to examine him, possibly to fit him with a hearing aid. However, on more thorough examination the hearing defect was placed at 10% or less. The adjustor for the insurance company asked for guidance and was advised to get one or two more otolaryngologists to evaluate the patient's defect. This suggestion was ignored, and he asked for a hearing before the Industrial Commission.

Now, "Here is a marvellous thing that ye know not from whence he is, and yet he hath opened mine eyes." St. John 9-30.

Since one opinion gave the man 90 to 95% loss of hearing in one ear, and another estimated 10% or less, the insurance adjustor and the Commissioner happily compromised on 55% loss of hearing, and the adjustor said he was "proud" of the result of his efforts.

Now the one thing that man doesn't have is 55% loss of hearing in one ear. He is either almost deaf or almost not deaf at all, but he is 55% deaf by the dictum of the Commission and compliance of the adjustor. Then so that everyone is real happy, the Commission wants to make an award for scarring, (It is a third degree burn, remember.), but not having an otoscope or flashlight, she could not see the ear drum or any scar, but she awarded five hundred dollars for disfigurement anyway. The total awarded this man, who has probably no loss of hearing and certainly no disfigurement, amounts to over eighteen hundred dollars.

What is the Industrial Commission's reason in giving an award for disfigurement which doesn't disfigure or deafness which may not actually deafen?

What is an adjustor thinking when he compromised such widely divergent opinions without a third or fourth evaluation?

What is the patient's thinking and what will be the trend among other injured employees?

What effect does this have on our statewide effort to encourage new industries to locate here?

As to the ratiocination of the Commission and adjustor, I beg to "pass" on the grounds of the Fifth Amendment.

The patient is in fool's paradise and can't wait to cash a four figure check. Later he will learn that a "55% loss of hearing in one ear" constitutes a hazard to him in working among dangerous moving equipment and consequently he should lose his job.

The effect on other employees will be a rush to reopen cases of trivial injuries in a hope of tapping such a source of easy money.

The effect on prospective industries for South Carolina is obvious. They make a complete study not only of labor cost but also of insurance costs and these include the awards of the Industrial Commission, and these are compared with other areas.

Most physicians in South Carolina have at some time appeared before an Industrial Commission in a hearing. I have always found the Commission to be courteous and considerate. Likewise the attorneys have exercised every effort to be considerate of the physician's time and opinions. However, if the final opinion is read, it is often a shock to find that an expert medical opinion has been reversed by the Commissioners in expert edict. The evidence presented seems too often inconsistent with the decision rendered.

So herein is a "marvellous thing"—our state government appoints and pays an Industrial Commission whose decisions deter industries locating there, and at the same time expends effort and money to bring industry here.

As physicians we like a recommended treatment along with the diagnosis, and the condition considered here can be cured.

First, the medical testimony should not be disregarded by the Commission, and to assist them the governor has appointed a Medical Advisory Committee for the Industrial Commission. We on this committee have impressive titles but never to my knowledge have been called upon. These doctors would be glad to be of service.

Also a round table discussion by physicians and adjustors would make for understanding and fuller cooperation.

The physician strives to give the patient the best treatment possible and in the industrial case this requires the cooperation of the employer as to treatments and job adjustments, the insurance carrier for fair compensation, and the Commission to distinguish between the true and the false in the disabled and the malingering.

NEED FOR COINSURANCE IN HEALTH CARE PLANS STRESSED BY DOCTOR

The following article by Dr. Judson S. Griffin of Binghamton, N. Y., president of the Broome County Medical Society, was first published in the society's official publication. It so impressed the editor of the Binghamton Press that he reprinted it in full. It should be borne in mind that the article was written for an audience of doctors—not insurance people or even the general public.

It is rapidly becoming apparent that if the field of medicine is going to survive under the free enterprise system in this country, rather than becoming the captive of a strong socialistic tide, it must do so on the shoulders of the private health insurance industry. The responsibility for fulfilling this herculean task of financing medical care at reasonable cost rests with the people, the medical profession, and the private insurance industry itself.

The public, for its part, must realize that the cost of medical care must be figured in the daily cost of living as are food, shelter, clothing, taxes, automobiles, etc., and should be financed as such—daily making provision for a potential medical expense which, when it becomes a reality and strikes the unprepared, imposes a financial burden which could become a catastrophe.

The public can procure protection by careful, intelligent, selection of health insurance plans. It must realize that, generally, the insurance value received in terms of benefits is in direct proportion to the cost of the plan itself. A low premium plan will provide lower payments for hospitalization and physician fees than will a similar plan with higher premium cost.

First-Dollar Costs Most

It must also realize that the most expensive type of insurance plan is that which attempts to provide total cost for an illness and particularly payment for the first dollars spent. It is only natural for an individual, a union, or an industry to desire complete and total coverage for medical expenses but this is very costly whether done under private insurance plans or under a government socialized plan.

The reasons for this are that total or early payment plans encourage over-use and abuse of medical care and spiral the over-all cost. For example—if a patient has full insurance coverage and is ill, he may be quick to seek physicians' services, laboratory and x-ray studies and hospitalization whether they are needed or not. When hospitalized he may be less eager to terminate his hospital stay because he feels that the insurance is covering all cost.

This is not to be interpreted as an indictment of the public but is human nature in action on the part of some, and as a result, medical costs under such a plan must spiral, and the participant will pay in the end with increased premium costs, or as in the case of socialized medicine with prohibitive taxes.

In my opinion, a coinsurance plan, with the individual sharing the cost of medical care with the insurance company underwriting the plan, shows greater promise in achieving the goal of medical coverage at reasonable cost. Under such a plan, there may be a deductible factor as there is with automobile collision insurance, with the patient paying the $50 to $100 or higher as the case may be, for medical

expenses incurred during a calendar year. Thus, unnecessary use of medical care is discouraged.

Beyond the deductible factor, the insurance comes into play, offering wide benefits but with the patient still participating, paying 10% - 20% of all costs above the deductible amount. Thus overuse is discouraged.

Many will immediately say that they are paying for insurance and still have to pay on medical bills under such a plan. This is true, but on the average, even with money out of pocket, in addition to that paid for coinsurance plans, the over-all cost to the individual must be less in that overuse and abuse are most effectively curbed. The insurance industry including Blue Cross and Blue Shield may well say, "We can't sell these plans effectively." The people, unions and industries won't subscribe to them in sufficient numbers. The truth of the matter is that some already are using similar plans and with proper understanding more should.

People, by sharing in medical cost, as in coinsurance plans, will assist the medical profession and the insurance industry in curbing abuse and overuse. The medical profession, for its part, must help in explaining the merits of various insurance plans to patients and must contribute towards eliminating abuse, overuse, and if it occurs, overcharge for physician and hospital services.

The insurance industry for its part must accurately and clearly define the costs, merits and limitations of its multiple types of health insurance. It must write and sell plans that are useful, workable and fulfill the patient's needs. Its plans must contain built-in re-restrictions of overuse and abuse. It cannot expect the physicians alone to discipline the patients who have the plans in order to keep costs down. The physicians' primary role is to aid in healing the patient and this is so dependent upon proper physician-patient relationship that it cannot be tempered by the associated role of insurance disciplinarians.

Quality Medical Care

With understanding and cooperation, the public, the health insurance industry, the medical profession and allied services can procure and provide high quality medical care at reasonable cost under a free enterprise system. Thereby, adoption of a plan of government sponsored, socialized medicine with all its limitations and greater ultimate cost would not only be unadvisable, but unnecessary, and an important segment of human freedom is presrved—medicine.

W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

WARREN—SURGERY

A valuable new volume emphasizing today's principles of surgical disease rather than mere mechanical techniques.

SCHMEISSER — A CLINICAL MANUAL OF ORTHOPEDIC TRACTION TECHNIQUES

Clearly describes and illustrates the application and advantages of traction in the management of common fractures.

WECHSLER—CLINICAL NEUROLOGY

Helpful information on the diagnosis and management of virtually every clinical neurologic problem you'll meet in daily practice.

Book Reviews

CLINICAL BIOCHEMISTRY. Abraham Cantarow, M. D. and Max Trumper, Ph. D. 6th Edition. 776 pages. W. B. Saunders Co., Phila. 1962. $13.00.

This new edition of an excellent series of constantly improving texts on Clinical Biochemistry over the last 30 years deserves the same praise given previous editions. "The first edition appeared thirty years ago when clinical medicine was emerging from an era of domination by morbid anatomy and histology." Changes in interpretations of objective observations in clinical biochemistry have been faithfully and impartially presented in the previous editions. In the 6th Edition the entire text has been completely revised and rewritten. New material has been added on the diagnostic significance of blood enzymes, abnormal hemoglobins, renal tubular dysfunction and intestinal malabsorption syndromes. The various aspects of metabolism, normal and abnormal, are presented accurately with adequate illustrations, graphs, tables, and equations. The mechanics of functional processes are presented in a logical manner with explanations of applications to clinical medicine without making it a medical text. The significance of abnormalities in chemical findings is presented and discussed in an excellent manner. This text is recommended to all students of modern biochemistry and clinical medicine.

William M. McCord, M. D., Ph. D.

THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS, VOLUME 3: DIGESTIVE SYSTEM, PART II: LOWER DIGESTIVE TRACT. Frank H. Netter, M. D. Ciba Foundation. $15.00.

The publication of this volume on the Lower Digestive Tract completes the three-part volume on the digestive system. Part 1 on the Upper Digestive Tract and Part 3 on the Liver, Billiary Tract and Pancreas have been published and previously reviewed.

Here again the artist, Dr. Netter, and the editor, Dr. Oppenheimer, along with some twenty contributors and consultants, have produced a masterful volume with some 200 full color plates and descriptive

texts covering all phases of the lower digestive tract, including its development, anatomy, functional and diagnostic aspects, diseases, injuries, and hernias. A cross-referenced index and a bibliography are included. These volumes continue to be sold at cost.

This is a unique and beautiful work, worth much more than its cost, and although the text is necessarily somewhat abbreviated, it is completely suitable for study, for review, and for certain aspects of teaching. The excellent color plates by Dr. Netter also are helpful in patient explanations.

This book could be highly recommended to students of anatomy, doctors in the practice of general medicine, internal medicine, and gastroenterology, and surgeons dealing with the digestive tract.

C. W. Legerton, Jr., M. D.

TREATMENT OF INJURIES TO ATHLETES. Don H. O'Donoghue. W. B. Saunders Company. Philadelphia - London - 1962. $18.50.

Dr. O'Donoghue is better fitted than almost anyone in the country to write this book, as he has had extensive experience and has written frequently on this subject. While much of the material can be found in the routine orthopedic text, the scope of athletic programs in this country warrants the material being gathered into a single volume touching on all phases of athletics. The importance of proper treatment of the patient, rather than sacrifice to the athletic program of the school is properly stressed and one chapter is devoted to prevention of injury by urging a proper conditioning program and good equipment.

As might be expected, open reduction of fractures and suture of ligamentous injuries is recommended highly. In some instances where others might use closed methods.

The work represents a fine addition to medical literature on the subject and will prove useful not only to the orthopedist, but to general practitioners, coaches, trainers and other persons dealing with athletic programs.

John A. Siegling

DOCTORS OF DARLINGTON COUNTY, SOUTH CAROLINA, 1760-1912 by Horace Fraser Rudisill. Published by the Darlington County Historical Society, Darlington, S. C., 1962. $6.00.

For one who has begged in vain for information about our South Carolina doctors, this sort of book is a bonanza. The author has attempted to find, and we judge he has succeeded in obtaining whatever information is to be had about the doctors of Darlington County from the earliest recorded times to 1912. He has managed to obtain photographs of many of them and he has examined local records meticulously to find material for the completion of his brief book of 86 pages.

While there are no great figures in medicine included, the book gives a good cross-section of the type of practice which was carried on in a South Carolina county. A number of these physicians were druggists as well, many of them served in the medical department of the Confederacy, and others participated in other wars. There are anecdotes and comment. The author is to be congratulated on the production of a work which will be of much interest to later times and is now a competent source of information.

JIW

COLLEGE STUDENTS IN A MENTAL HOSPITAL. By Carter C. Umbarger, James S. Dalsimer, Andrew P. Morrison and Peter R. Breggin. Grune and Stratton. New York. 1962. $5.75.

This paperback is a very readable and concise report of the efforts and results of over 2000 college students in the Boston area. Since inception of the program in 1954 by a student, these students have given several hours a week to voluntary service in a social worker capacity to the many neglected and often forgotten patients of a typical state hospital in which therapeutic efforts remain at a premium.

J. D. Morgan, M. D.

PAIN AND ITCH—NERVOUS MECHANISM. Ciba Foundation Study Group No. 1. Little, Brown Company, Boston. Pp 120. $2.50.

The Ciba Foundation, a unique institution established under British trust law, holds small conferences around an eminent member of the Foundation's Advisory Board who edits the proceedings. This Study Group No. 1 is concerned with the nature of pain and itch. Itch is included because there is evidence suggesting a common signaling mechanism, therefore investigations can be done by the same experimental and clinical methods. Each section ends with a valuable discussion from the entire group. In spite of improvements in techniques, the results cannot be trusted in the study of the smallest non-medullated nerve fibers which seem to be involved in pain and itch. The study of these fibers is the main subject of the monograph.

Many interesting questions are raised and discussed. Why does scratching relieve itch or tickle? Is it actual destruction of the nerve endings? Does one fiber really mediate the impulse giving rise to sensations of itch and pain? These fundamental discussions are particularly interesting and stimulating to anyone concerned with investigative physiology of pain and itch.

Kathleen A. Riley, M. D.

BETWEEN US WOMEN. Laura E. Weber, M. D.. Doubleday & Company, Inc. Garden City, New York. 1962. 153 pp. $1.95.

This is another book written for the pregnant patient. As might be expected from the title, it has a folksy style and brevity is not one of its virtues. The various subjects treated are not always in logical sequence and a number of unqualified statements would be challenged by many obstetricians. It is not as well bound and not nearly as well written as at least one book of similar price and purpose which has been available for many years.

J. Richard Sosnowski, M. D.

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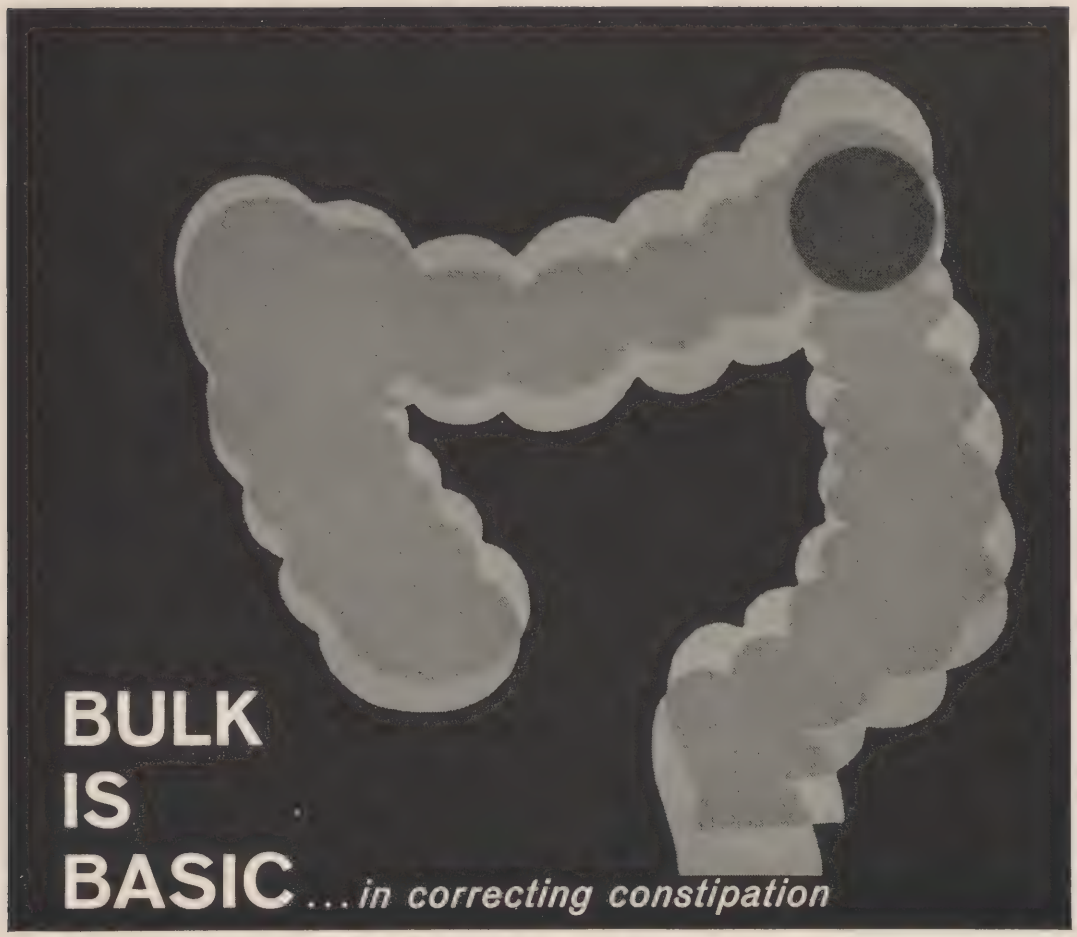
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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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University of Colorado Medical Center
Denver, Colorado.

Dr. Vince Moseley, Prof. of Medicine
Medical College of S. C.

Moderator—Dr. Dale Groom

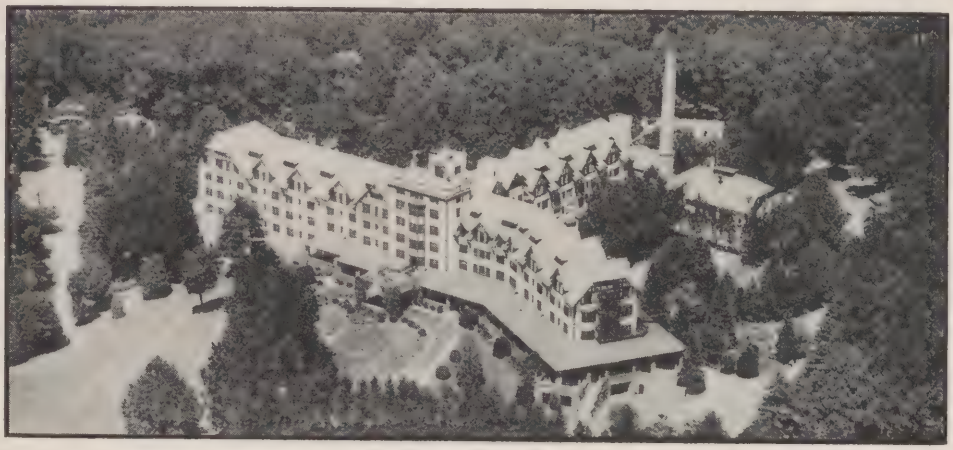
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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



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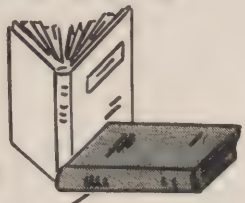
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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

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3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

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4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

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5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

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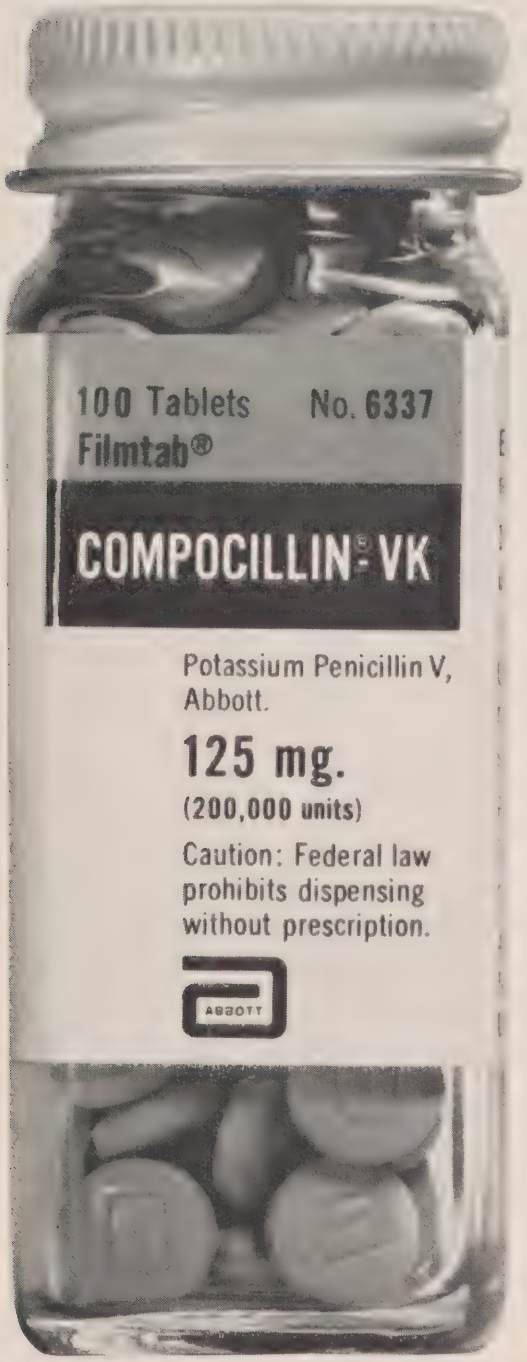
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2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

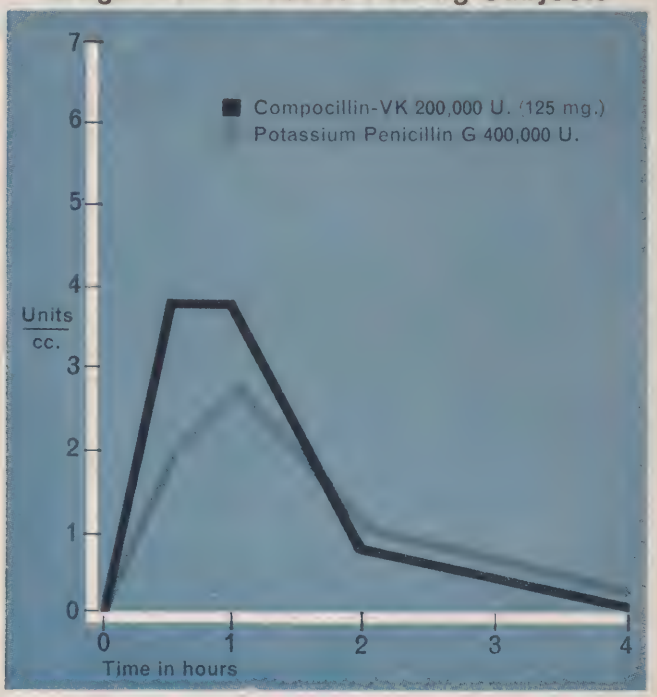
CW-7972

Here's a penicillin that gives you...

PATIENT ECONOMY WHEN YOU WANT IT



Single Oral Doses to Fasting Subjects*



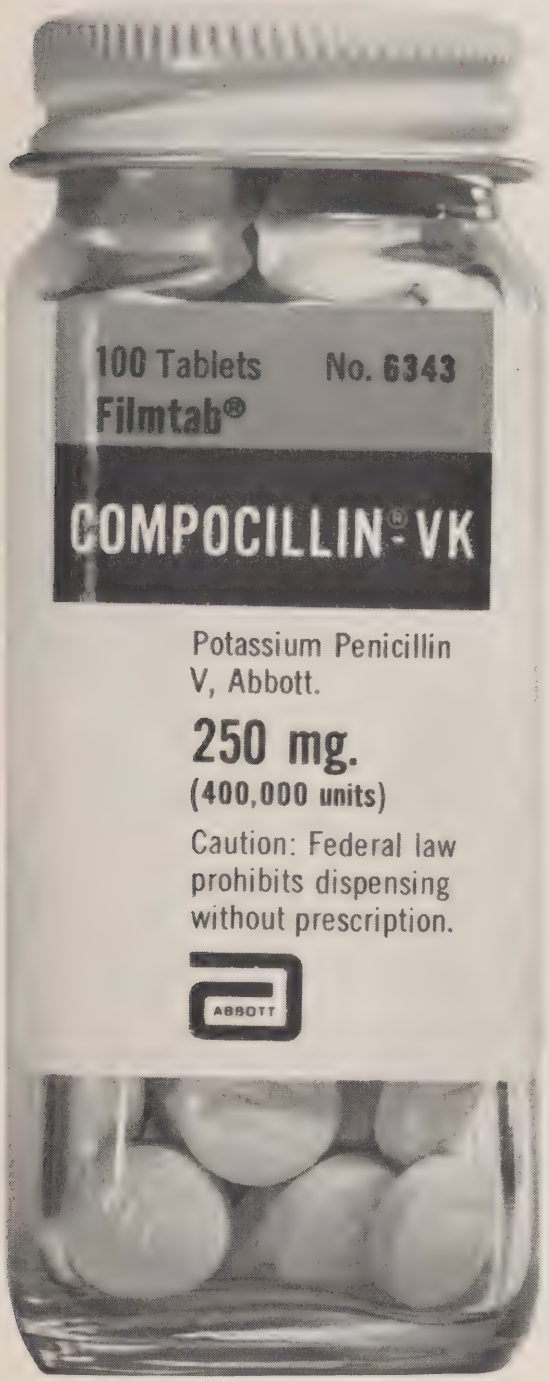
Consider milder bacterial infections

An example might be a respiratory infection. Here economy could be a definite factor in your thinking. In the chart above, you'll see that 200,000 units (125 mg.) of Compocillin VK produces blood levels at least equal to those obtained with 400,000 units of oral penicillin G potassium. This means that in less severe infections, Compocillin-VK may be given at *half* the dosage needed with oral penicillin G—with no sacrifice in blood levels. In these cases, the cost of Compocillin-VK therapy will be no more—and often will be less—than treatment with oral penicillin G.

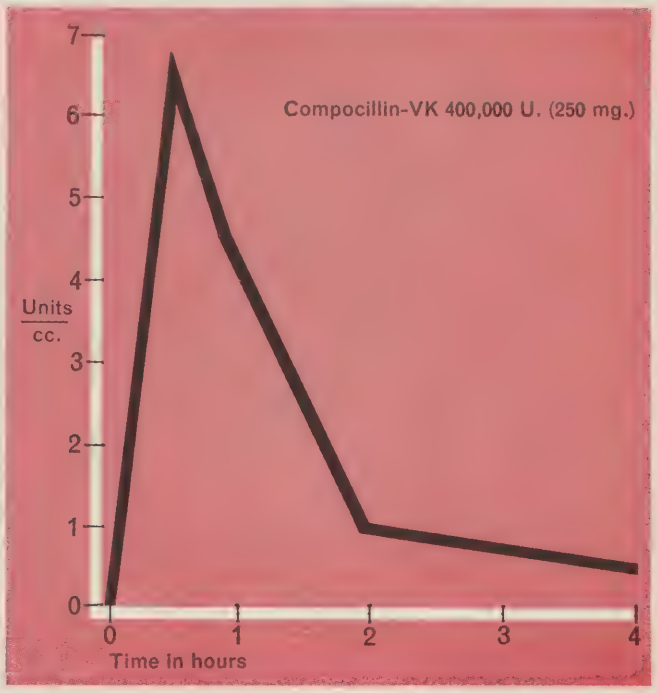
Compocillin-VK—the original potassium penicillin V • In Filmtab (125 and 250 mg.) and cherry-flavored Granules for Oral Suspension

Filmtab—Film-sealed tablets, Abbott: U.S. Pat. No. 2,881,085

PEAK EFFICIENCY WHEN YOU NEED IT



Single Oral Doses to Fasting Subjects*



Then, for severe infections...

. . . where your primary concern is high peak serum concentrations, you can prescribe Compocillin-VK at *full therapeutic dosage* and get the maximum antibacterial activity possible with an oral penicillin. The chart above shows the rapid peak blood levels obtained with 400,000 units (250 mg.) of Compocillin-VK. Actually, these peaks occur faster—and are higher—than those obtained with intramuscular penicillin G. Indeed, Compocillin-VK has been used in cases previously reserved for parenteral treatment. The safety advantage (oral vs. injectable) goes without saying.

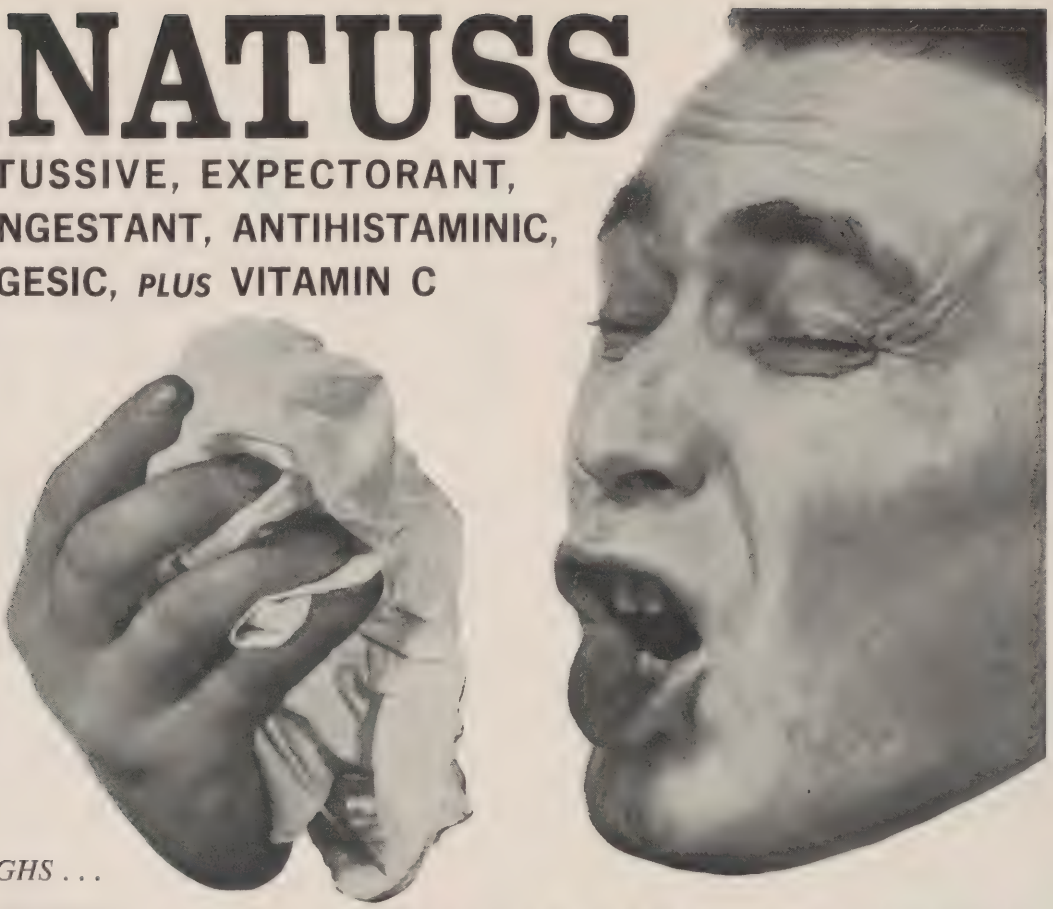
*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

ABBOTT LABORATORIES NORTH CHICAGO, ILLINOIS

210274

ANATUSS

ANTITUSSIVE, EXPECTORANT, DECONGESTANT, ANTIHISTAMINIC, ANALGESIC, *PLUS* VITAMIN C



- *COUGHS . . .*
- *ALLERGENIC REACTIONS . . .*
- *NASAL CONGESTION . .*
- *MINOR PAIN . . .*



ANATUSS TABLETS' UNIQUE PRESS COATING COMBINES 7 ACCEPTED INGREDIENTS FOR A 7 PRONG ATTACK ON RESPIRATORY SYMPTOMS . . .

At last — here is a tablet containing previously incompatible drugs which could not be administered in a single dosage form. ANATUSS is valuable in treating irritating coughs associated with allergic bronchitis or rhinitis; coughs and allergenic conditions associated with the common cold; chronic non-specific bronchitis; acute pharyngitis with cough; chronic pulmonary disease; post influenzal cough.

Each Tablet Contains:

IN OUTER COATING

Glyceryl Guaiacolate ..... 50 mg. N-Acetyl-P-Aminophenol ..... 300 mg.

IN INNER CORE

Dextromethorphan Hydrobromide .... 10 mg. Phenylephrine Hydrochloride .... 5 mg.
Phenylpropanolamine Hydrochloride 25 mg. Chlorpheniramine Maleate ..... 2 mg.
Ascorbic Acid ..... 100 mg.

Available in Bottles of 100 and 500 tablets. **ALSO** as **ANATUSS SYRUP**, combining the same valuable ingredients in a pleasantly flavored base.

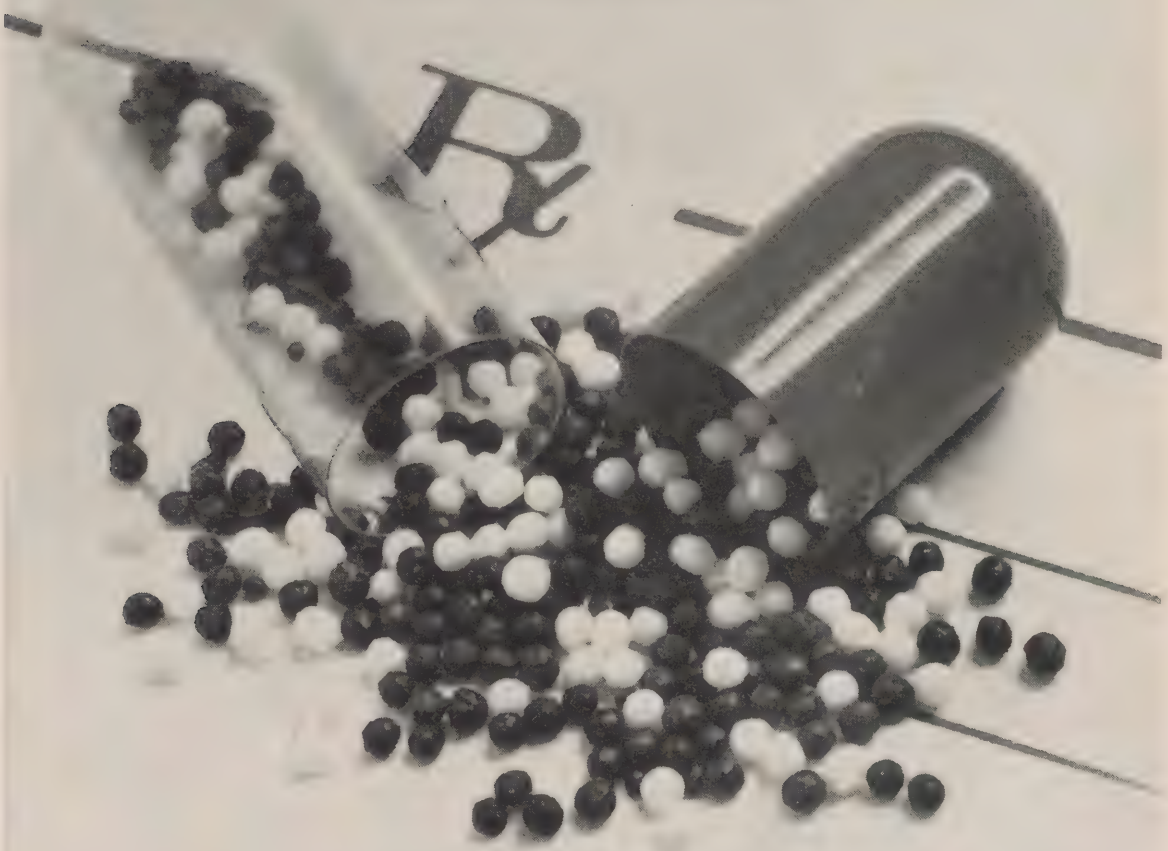
SAMPLES AND LITERATURE ON REQUEST

Mayrand, Inc. PHARMACEUTICALS
GREENSBORO, NORTH CAROLINA

663 gentle doses of iron in a single capsule, once daily

ONE-IRON™

(capsules of timed-release ferrous fumarate)



the best-tolerated ferrous iron
timed for release in the area of maximum absorption

A single capsule of ONE-IRON—taken once a day by your iron-deficient and even your iron-sensitive patients—sprinkles tiny particles of ferrous fumarate throughout the duodenum and jejunum over a four-hour period for virtually complete and trouble-free absorption.

Not only is maximum hemoglobin regeneration obtained, but the possibility of gastric discomfort, diarrhea or constipation from ionized iron is virtually eliminated.

Moreover, ferrous fumarate itself (the sole active ingredient of ONE-IRON) is better tolerated than ferrous sulfate, succinate or gluconate.[1-3]

Each timed-release ONE-IRON capsule provides ferrous fumarate, 325 mg. (5 grs.), equivalent to 107 mg. of elemental iron.

Dose—one capsule daily with breakfast.

Supplied—bottles of 100 and 1,000 clear and white capsules.

References: 1. Berenbaum, M.C. et al.: Blood 15:540, 1960. 2. Shapleigh, J.B. and Montgomery, A.: Am. Prac. & Digest Treat. 10:461, 1959. 3. Swan, H.T. and Jowett, G.H.: Brit. M.J. 2:782 (Oct. 24) 1959.

HART LABORATORIES
Division of A. J. Parker Co.
Winston-Salem, N. C.

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P. ... 2 Gm.
Pectin N.F. ... 225 mg.
Kaolin ... 3 Gm.
Opium tincture U.S.P. ... 0.08 cc.
(equivalent to 2 cc. paregoric)

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.



Marvelous low-residue meal—consommé, molded flaked fish, farina-plum pudding—and beer!

How to help your patient stick to a low-residue diet

What could be more acceptable to the patient who's tired of his low-residue diet than some truly appetizing dishes?

Consommé is delicious served jellied or hot. Eggs can be soft or hard-cooked by simmering. Flaked fish molded in lemon gelatin looks inviting.

For delicious "burgers," just moisten chopped beef with broth and mix in bread crumbs. Puréed vegetables, folded into well-beaten eggs (yolks and whites) and baked, make delectable "soufflés."

For a unique and delicious salad, try split bananas over cottage cheese, top with puréed apricots. For taste-tempting parfaits—alternate layers of farina pudding and puréed plums.



And a glass of beer can add zest to your patient's diet

pH-4.3,
104 Cal./8 oz. glass
(Average of American Beers)

United States Brewers Association, Inc.

For reprints of this and 11 other diet menus, write us at 535 Fifth Avenue, N.Y. 17, N.Y.

SPECIAL COUGH FORMULA

for Children

Pediacof®

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 ml.) contains:		
Codeine phosphate	5.0	mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) . .	2.5	mg.
Chlorpheniramine maleate	0.75	mg.
Potassium iodide	75.0	mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

Available on prescription only.

Exempt Narcotic

Winthrop
LABORATORIES
New York 18, N Y

scratching helps...



but Calmitol stops itching fast!

For every kind of pruritus—for adults or children—safe, fast-acting CALMITOL Ointment soothes itching on contact, helps prevent secondary trauma caused by scratching. And low-cost, conservative CALMITOL is non-sensitizing. CALMITOL Ointment is available at all pharmacies in 1½ oz. tubes and 1 lb. jars. For more stubborn pruritus, CALMITOL Liquid in bottles of two fluidounces.
THOS. LEEMING & CO., INC., New York 17

CALMITOL®

for anything that itches

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



Liquid asset

Now that we have added a new liquid-dosage form to our Panalba* family, you may prefer to begin treatment with Panalba KM* Drops when dealing with infections caused by susceptible organisms in infants and children. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why Panalba offers excellent chances for therapeutic success.

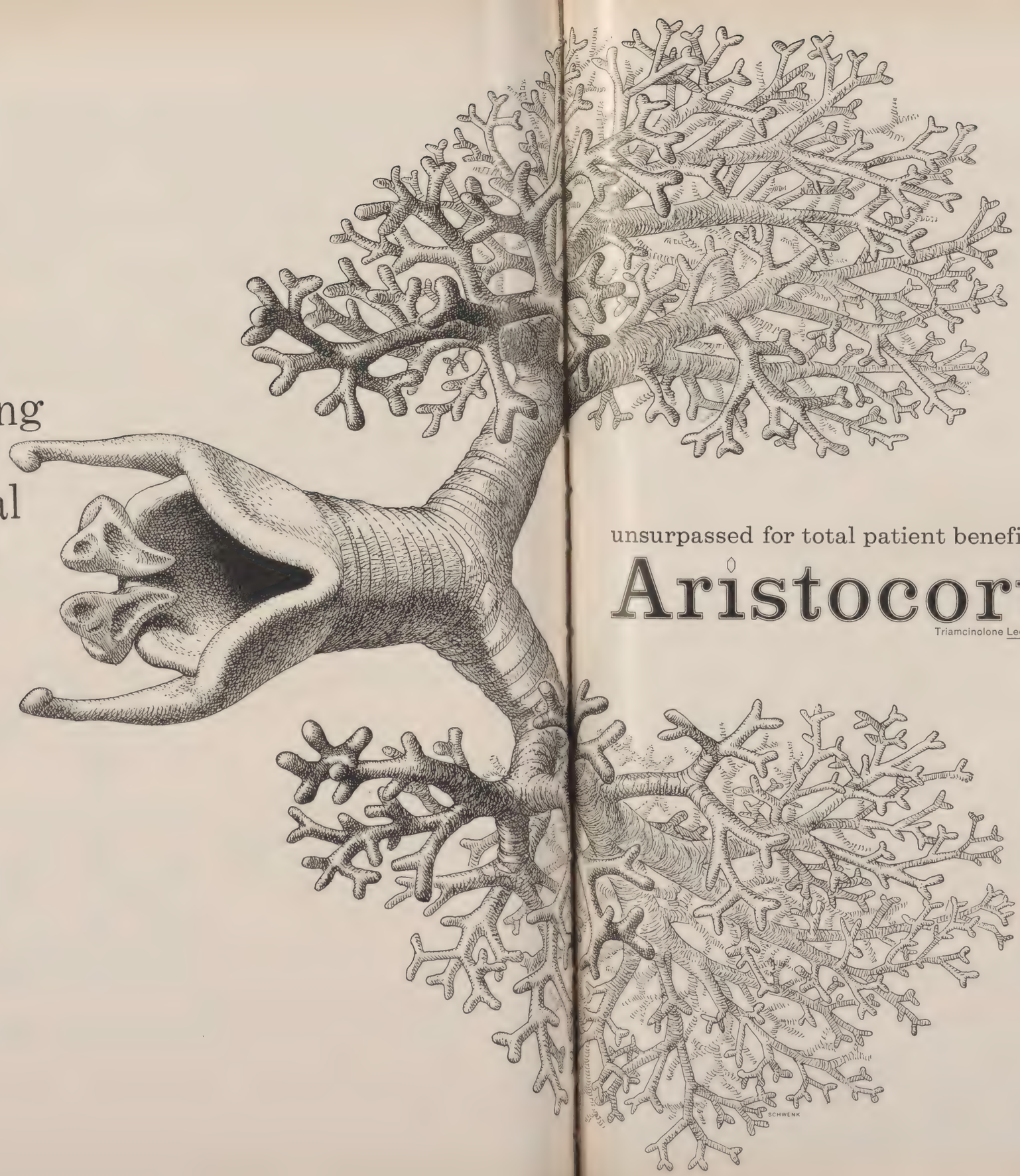
Supplied: Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:
Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.
Usual pediatric dosage:
½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.
(Reminder advertisement. Please see package insert for detailed product information.)

*TRADEMARK, REG. U.S. PAT. OFF.
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KALAMAZOO, MICHIGAN

Upjohn

gratifying
relief
in bronchial
asthma



unsurpassed for total patient benefits

Aristocort®

Triamcinolone Lederle

With ARISTOCORT, asthmatic patients obtain sustained relief of wheezing, dyspnea, and spasmodic coughing. It is of particular value in ameliorating severe attacks that may have serious sequelae. With ARISTOCORT, many patients who might otherwise be invalids are able to continue their customary livelihoods or maintain their regular household activities. Yet this symptomatic relief is not often accompanied by the hormonal collateral effects —sodium retention, edema, emotional disturbance, insomnia, voracious appetite— that so often have been a deterrent to steroid therapy.

SUPPLIED: Scored tablets (three strengths), syrup and parenteral. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York

when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent...often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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PARKE, DAVIS & COMPANY, Detroit, Michigan



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specific for anxiety & tension

Librium

The singular specificity of Librium in controlling anxiety and tension has proven to be an advantage in a wide range of disorders characterized by anxiety of varying degrees. Notably effective in patients whose symptoms are primarily emotional, Librium is equally valuable when organic disease is aggravated or prolonged by accompanying anxiety. Coupled with its effectiveness is an outstanding record of safety. Librium has few, if any, of the unwanted side effects associated with tranquilizers and daytime sedatives—no extrapyramidal effects, no autonomic blocking, and no dulling of mental alertness. Consult literature and dosage information, available on request, before prescribing.

the successor to the tranquilizers

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride

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